Malatest & Associates Ltd.

SUMMARY REPORT
THE STUDENT HEALTH INITIATIVE
EVALUATION PROJECT

Prepared for
THE STUDENT HEALTH INITIATIVE
EVALUATION COMMITTEE

Prepared by:
R.A. Malatest & Associates Ltd.
206 – 10050 112TH Street
Edmonton, AB T5K 2J1

Phone: (780) 448-9042
Fax: (780) 448-9047

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EXECUTIVE SUMMARY

Background

Highlighted in this report are the key findings of *the Student Health Initiative Evaluation Project* instituted by the Student Health Initiative Evaluation Committee in the spring of 2000. The Student Health Initiative (SHI) represented a co-ordinated approach by the provincial partners of Alberta Learning, Health and Wellness, Children's Services and the Alberta Mental Health Board to enhance health and related support services for children with special health needs registered in school programs.

The Student Health Initiative is an initiative with funding of approximately $25.6 million annually. To ensure that the programs and services met the needs of local communities, funding and program delivery decisions were the responsibility of local education (including school jurisdictions, Early Childhood Services, private schools and charter schools), regional health authorities, mental health and child and family services authorities. In 1999/2000, there were 26 Partnerships delivering services funded under the Student Health Initiative.

Purpose of the Evaluation

The Student Health Initiative represented a new model through which integrated student health services could be provided at the local level. As this new initiative generated a significant change in service delivery, an evaluation framework by which the effectiveness of the Initiative could be assessed was developed.

Given that the Initiative has been in place for a relatively short period of time, this evaluation is not intended as a comprehensive assessment of the overall impact(s) of the Initiative. Rather, the evaluation is a means to identify key findings associated with the design, implementation and early outcomes associated with the Student Health Initiative. In this context, therefore, this research should be viewed as a formative, rather than a summative, evaluation of the Student Health Initiative.

Key Evaluation Findings

Highlighted below are some of the key evaluation findings and conclusions of the *Student Health Initiative Evaluation Project* as based on the synthesis of information collected from almost 500 individuals and/or organizations directly or indirectly involved with the Student Health Initiative. Key evaluation results are presented under the following headings: Congruence with the Alberta Children's Initiative; Program Design, Implementation and Support; Collaboration and Partnership Issues; Service Delivery Issues; and Preliminary Assessment of Outcomes.

Congruence with the Alberta Children's Initiative (ACI)

Most Stakeholders feel that the Student Health Initiative is congruent with the goals and objectives of the Alberta Children's Initiative.

Overall, the majority of stakeholders and Partnerships surveyed were of the opinion that the Student Health Initiative was congruent with the goals and objectives of the Alberta Children's Initiative[1]. For example, almost all (96.0%) Partnerships noted that the SHI fit in well with the ACI, and a similar high proportion (88.0%) of Partnerships noted that their respective student health Partnership fit in well with the Alberta Children's Initiative.

Stakeholders cited numerous activities to suggest inter-ministerial support of the Student Health Initiative.

Interviews with members of the Provincial Working Group (PWG) as well as with Assistant Deputy Ministers and Deputy Ministers of the provincial partners (Learning, Children's Services) provided additional information with respect to the extent to which the Initiative was supported by the various partnering agencies. In general, key informants noted that the high level of support for the Initiative would indicate that the Initiative was consistent with the vision and objectives of the Alberta Children's Initiative. Key stakeholders cited several factors that demonstrated middle and executive level management support of the Student Health Initiative including:

- high level of support for the Initiative, by both middle and senior management in the key departments associated with the Initiative;
- establishment of an inter-ministerial working group, the Provincial Working Group (PWG) that allocated considerable time and resources to the Initiative;
- use of collaborative processes at the provincial level to define program objectives and program implementation.

Program Design, Implementation and Support

Almost all Partnerships felt that the Student Health Initiative had resulted in improved delivery of services to children with special health needs.

Overall, the results of the partnership surveys suggest that the Student Health Initiative has prompted improved delivery of services to children with special health needs. For example, partnerships noted that the SHI resulted in additional incremental programs and services being provided to children with special health needs, and access to student health services for children had increased. More than three-quarters of the Partnerships also noted that the SHI had prompted better coordination of services for children with special health needs.

[1] Currently, this is the *Alberta Children and Youth Initiative*.

The limited time available for Partnership formation and development of Joint Service Plans resulted in some implementation problems.

Numerous regional partners and service delivery agencies noted that because they had only a very short time (i.e., fewer than four months) to establish their Partnership and develop a Joint Service Plan, Partnerships experienced some difficulties during implementation.

Among the difficulties/problems cited by evaluation participants were:

- lack of clearly defined partnership boundaries;
- initial uncertainty as to whether funds were to be pooled or re-distributed among partners;
- lack of time to develop partnerships/Joint Service Plan; and,
- onerous reporting requirements.

Overall, the majority of Partnerships were satisfied with the support provided by the Provincial Working Group.

In general, with the exception of the provision of adequate financial resources, most Partnerships were satisfied with the support provided by the Provincial Working Group. For example, there was considerable support cited with respect to information resources provided (64.0% of Partnerships indicated such resources were helpful or very helpful) and the overall support provided by the PWG (56.0%).

Many partners questioned the funding formula used to derive base funding allocations.

A number of regional partners noted that they had very little information as to how SHI funding was derived for the partners and/or Partnership. Several individuals also noted that the base funding allocations were partially based on the number of students with mild/moderate disabilities - classifications which traditionally have not been submitted to Alberta Learning on a comprehensive or systematic basis.[2] In this context, some partners felt that they received less than their "fair share" of SHI funding.

Partnerships operating in remote/rural regions also noted that the cost to operate the partnerships and provide student health services would be higher than costs associated with service delivery in urban partnerships. Several individuals expressed that the SHI funding model should reflect the cost differences associated with operation of partnerships (i.e., travel time to attend meetings, etc.) as well as the difficulty in providing student health services in rural/remote regions as opposed to urban centres.

[2] Stakeholders noted that coding for students with mild/moderate disabilities, was not uniform across school authorities.

Almost all partners cited concerns about inadequate funding for administration-particularly for start-up/implementation.

Almost all Partnerships (95.9%) indicated that the lack of funding for administrative costs during partnership development was a major challenge (79.2%) or of some concern (16.7%). Only one of the 25 Partnerships felt that there was adequate financial resources available to help the Partnership during the planning stage.

While some partners felt that the funding allotment (4.5% of the total funding allocation) would be sufficient to cover administration costs once the Partnership had reached an "operational stage", few partners felt that the additional one-time 5% allocation for the start-up was adequate to cover the considerable costs associated infrastructure (i.e., telephone, computers, etc.) and other start-up costs.

Issues associated with the sustainability of the Initiative

In addition to completion of numerous interviews and detailed case studies, the research team also reviewed the Annual Reports submitted by the Partnerships. This review included an analysis of data from 13 Annual Reports that were available for review by the Consultant. Of the Annual Reports that the Consultant was able to review, most indicated that their respective Partnership was in a surplus position as of August 31, 2000.

Many Partnerships noted that their surplus was due in large part to the inability to hire sufficient staff during the initial implementation of the Initiative. In many of the Annual Reports, it was noted that it was unlikely that this surplus would exist in the future as Partnerships filled vacant positions.

Some Partnerships noted the need for long term funding which could affect the future delivery of services. For example, several Partnerships stated that their current budget did not include any allowances for cost of living increases or wage settlements which would result in increased costs and/or necessitate reduction in services. It was noted that future SHI funding should include allowances for increased staff costs and inflation.

Similarly, several Partnerships noted that it would be important for the government to clarify long-term funding of the Initiative to enable Partnerships to undertake effective planning with respect to staffing, accommodation and service delivery.

Collaboration and Partnership Issues

Most Partnerships reported that they had reached a stage where the Partnership was "functional" in terms of governance, needs assessment and accountability.

The majority of the Partnerships surveyed felt that their Partnership was functional in terms of governance, needs assessment and accountability, for example:

- 96.0% of Partnerships felt that there was a commitment to the partnership agreement amongst all partners;

- 88.0% of Partnerships indicated that an effective decision-making process had been established; and,
- 88.0% of Partnerships agreed that there were appropriate accountability mechanisms in place.

The Student Health Initiative has served as a catalyst to enhance collaboration and coordination of services.

Overall, the results of the evaluation suggest that the SHI has served as a catalyst to enhance collaboration between various partner organizations in delivering student health services. For example, more than three-quarters of the Partnerships noted that SHI enhanced the sharing of information between partners (92.0% of partnerships reported an improvement or significant improvement in this area), as well as improvements in the area of planning (88.0%) and decision-making (88.0%). Even two-thirds (68.0%) of Partnerships noted that there had been an improvement in terms of collaborating on pooled funding.

In addition to the positive assessment by the Partnerships, the results of the telephone survey of parents suggest that a majority of parents also feel that services are better coordinated. For example, almost two-thirds of parents (62.9%) agreed or strongly agreed that the health and education staff helping their child were "working together".

Regional partners, service providers and parents feel that the SHI has contributed to better coordination of services.

Overall, it appears that the Student Health Initiative has resulted in better coordination of health services. The majority of Partnerships agreed or strongly agreed that the Initiative enhanced the understanding of the programs/services offered by the respective partner agencies (96.0%), and that the SHI has resulted in better coordination of services (76.0%).

Overall, the results of the evaluation suggest that Partnerships have made only limited progress in fostering community/parental involvement.

Less than one-third (32.0%) of the Partnerships felt that there was sufficient involvement of children, families and community members within the Partnership. Similarly, a significant proportion of Partnerships noted that parents' lack of understanding of the Student Health Initiative was a major challenge (cited by 12% of Partnerships) or of some concern (64.0%).

The Parent Survey confirmed that most parents had little knowledge of the Student Health Initiative and only limited opportunity to provide input into the SHI Partnership, as fewer than one-half of parents surveyed indicated that they were knowledgeable about the Student Health Initiative or that they had opportunity to provide input into the SHI Partnership.

Service Delivery Issues

Most Partnerships have indicated that they had or continue to have difficulty in hiring health professionals.

It became evident early in the evaluation that most, if not all, Partnerships were experiencing difficulties in recruiting health professionals. Most organizations noted the sudden demand for staff completely outstripped the available supply. More than one-half (58.3%) of Partnerships noted that the lack of human and other resources was a "major challenge" in the implementation of their service plan, and a similar proportion (54.2%) reported the limited availability of qualified front-line staff as a "major challenge".

Rural Partnerships noted that staffing their newly created positions was particularly problematic.

Partnerships are just beginning to establish monitoring and evaluation processes.

At the time of the field visits and Partnership Surveys, most Partnerships were just beginning to establish internal monitoring and evaluation activities. Review of the 13 Annual Reports indicated that while all Partnerships are planning to undertake some evaluation activities, there is a considerable range in evaluation approach and activities. For example, whereas some Partnerships have established performance targets and implemented data collection activities to establish whether the target has been or will be met, other Partnerships have noted that they will be completing "self assessments" to ascertain the effectiveness of their program delivery.

Preliminary Assessment of Outcomes

Although the evaluation was primarily designed to assess the initial design and implementation of the Student Health Initiative, the evaluation also examined some preliminary outcomes associated with the Initiative. This preliminary assessment of outcomes was based on information obtained from surveys of the Partnerships and parents, as well as through an examination of data contained in Annual Reports.

Evaluation participants have indicated that the SHI has resulted in both quantitative and qualitative improvements in the delivery of health services to children.

Evaluation participants cited numerous examples as to how the Student Health Initiative has resulted in improved health services for children. In general, the positive outcomes can be classified as follows:

- enhancements in existing services;
- introduction of "new" services; and,
- provision of services to target populations that had been traditionally under-served or not at all served.

Parents have identified several positive outcomes associated with the introduction of the Student Health Initiative.

The majority of parents surveyed indicated that they had noted improvements in several areas including: opportunities for their child to actively participate in school activities (57.4% of parents agreed or strongly agreed), their child's academic achievement (65.2%), and their child's ability to meet goals (57.4%). A lower proportion of parents (39.3%) felt that their child's attendance at school had improved[3].

Although most Partnerships stated that they were now providing more/enhanced services, several Partnerships noted areas that still required services.

It should be noted that while most Partnerships were satisfied with their provision of more/improved services, several Partnerships noted that they had experienced difficulty in recruiting and providing services in the following areas:

- speech language; and
- behavioural specialists.

Some consideration should be given to expanding the scope to include additional populations.

While most evaluation participants noted that the Student Health Initiative should not be viewed as a panacea for all student issues, there were several areas in which respondents felt that there were service delivery gaps. Among these included services to Aboriginal students schooled on-reserve, pre-school aged children and "at risk" students such as drop-outs and victims of "bullying".

Overall Assessment of the Student Health Initiative

Stakeholders, regional partners, service providers and parents were very positive in their overall assessment of the Student Health Initiative.

Notwithstanding issues or concerns identified with implementation and funding, almost all evaluation participants indicated that the Student Health Initiative was a positive development in terms of enhancing both the quality and quantity of health services provided to students with special health needs. For example:

- 84.0% of Partnerships agreed or strongly agreed that the time and effort spent in forming the Partnership was worthwhile given the additional resources provided;
- 84.0% of Partnerships indicated that participation in the SHI was a positive experience for their partnering organizations;
- almost all (92%) Partnerships agreed or strongly agreed that the Partnership has or will improve outcomes for students with special health needs. Only 2 of the 25 Partnerships were unsure as to whether the SHI would result in an improvement in such outcomes.

[3] It should be noted that as some parents noted that their child's attendance was satisfactory prior to and after the implementation of the SHI, student attendance was not an issue among all parents surveyed.

Summary of Overall Evaluation Conclusions

Overall, the results of the *Student Health Initiative Evaluation Project* suggest that the Initiative is meeting an important need in terms of the provision of health services to students with special health needs. Information collected during the evaluation confirms that the Student Health Initiative has substantially increased the collaboration, coordination and overall delivery of services to special needs students.

Results further suggest that the SHI is realizing many positive successes with respect to student outcomes. For example, Partnerships reported that the Initiative has resulted in more students receiving services, the delivery of more specialized services, reduced waiting times and extension of services to student populations that were traditionally under-served or not served at all. As well, information obtained from parents suggest that the Initiative has resulted in their child(ren) being better able to meet learning goals, has contributed to greater participation in school activities and has led to overall improvement in their child's achievements at school.

Notwithstanding the considerable time and resources that were required to establish the Partnerships and develop Joint Service Plans, these "Partnerships" are viewed as a key success factor for the Initiative. The inclusion of all sectors was seen as a building block in the development of an integrated and coordinated service delivery plan that met the needs of all children, irrespective of the school district or authority to which the child was affiliated. Almost all Partnerships noted that despite the time and resources involved, participation in the Student Health Initiative was a worthwhile endeavor.

While the Student Health Initiative can be characterized as a "positive" Initiative, evaluation participants noted that there were a number of challenges associated with implementation. Lack of time, insufficient financial resources, and only limited provincial support were identified as challenges or barriers to effective implementation. Similarly, almost all Partnerships noted that they have been unable to fill many positions and as a result, have recorded a significant surplus in the first year of operation. Staffing issues were identified as a key issue in terms of implementation and many Partnerships continue to report that they have been unable to fill some positions.

Looking forward, it is clear that the Student Health Initiative will remain an important component in the delivery of health services to students with special health needs. However, there are several areas that have been identified for review including funding, reporting requirements and addressing perceived service delivery gaps.

In summary, based on the review and synthesis of the extensive information collected as part of this evaluation, it appears that to the Partners involved in the Student Health Initiative, that the concept of the Initiative represents an effective model for coordinating the planning and delivery of health services to students with special health needs. It should be noted, however, that it was not within the scope of this evaluation to identify the extent to which the SHI has influenced long-term outcomes with respect to student health and learning outcomes. Such analysis would need to be part of a more comprehensive summative evaluation.

Malatest & Associates Ltd.

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Table of Contents

Executive Summary i

Acknowledgements 1

PART A: BACKGROUND 2

Section 1: Introduction 2
1.1 Background 2
1.2 Purpose of the Evaluation 2
1.3 Evaluation Period 3

Section 2: Research Methodology 4
2.1 Scope of Work 4
2.2 Data Analysis and Validity of the Findings 5
2.3 Research Limitations 5
2.4 Report Structure 6

Section 3: History of the Initiative and Activities 7
3.1 Overview 7
3.2 Program Implementation and Support 8
3.3 Monitoring and Reporting 8

PART B: EVALUATION FINDINGS 10

Section 4: Congruence with the Alberta Children's Initiative 10
4.1 Stakeholder Perceptions of the Congruence with ACI 11
4.2 Assessment of Inter-Ministerial Collaboration 13

Section 5: Program Design, Implementation and Support 15
5.1 Perspectives about the Design of the Student Health Initiative 15
5.2 Funding Issues 18
5.3 Satisfaction with Implementation Support 20

Section 6: Collaboration and Partnership Issues 24
6.1 Opinions as to the Effectiveness of the Partnership Model 24
6.2 Views About Partnership Collaboration and Service Coordination 25
6.3 Inclusion of Children, Families and Community Members in the Planning Process 28

Section 7: Service Delivery Issues 30
7.1 Service Delivery Models Developed 30
7.2 Rural/Remote Service Delivery Issues 31
7.3 Staffing Issues 32
7.4 Monitoring and Evaluation Activities 33
7.5 Program Expenditures 33

Table of Contents (continued)

Section 8: Preliminary Assessment of Outcomes 34
8.1 Preliminary Identification of the Outcomes Associated with the Student Health Initiative 34
8.2 Identification of Unmet Needs 37
8.3 Overall Assessment of the Student Health Initiative 39

PART C: SUMMARY AND CONCLUSIONS 42

Section 9: Summary of Overall Evaluation Conclusions 41

TABLES:

Table 4-1 Partnership Opinion About the Extent to Which the SHI has Prompted Increased Collaboration with Other ACI Initiatives 12
Table 5-1 Overall Perceptions of the Student Health Initiative Partnership Survey 16
Table 5-3 Resources Provided by the Provincial Working Group 22
Table 6-1 Opinions As to the Effectiveness of the Partnership Model-Selected Issues 25
Table 7-3 Staff Shortages by Partnership (Small and Large Partnerships) 32
Table 7-5 Planned and Actual Program Expenditures – 1999/2000 33
Table 8-1 Parental Perceptions with Respect to Changes in Services-Parent Telephone Survey 36

CHARTS:

Chart 4-1 Partnership Opinion with the Extent to Which the Student Health Initiative was Congruent with the Student Health Initiative 11
Chart 5-1 Extent to Which Time Required to Form Partnership was a Major Challenge or of Some Concern 18
Chart 5-3 Partnership Opinions Regarding Helpfulness of Government/ PWG Supports 23
Chart 6-2A Improvements at the Individual Partnership Level 26
Chart 6-2B Partnership Opinion with Respect to Service Coordination Issues 27
Chart 6-3 Parental Satisfaction with their Knowledge, Opportunity to Provide Input, and Level of Involvement with their Local Student Health Initiative Partnerships 28
Chart 8-1A Partnership Assessment of the Outcomes Associated with the Student Health Initiative 35
Chart 8-1B Parental Opinion About Changes in Services by Student Grade Level 37

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Daryl Bertsch, Chair	Alberta Children's Services
Lynne Burnett, former Chair	Alberta Health and Wellness
Perdita Baier Law	Alberta Children's Services
Katherine Caine	Capital Health
Sharon Campbell	Alberta Learning
Bill Chalmers	Chinook's Edge School Division
Chris Diachuk	Elk Island Catholic Separate Regional Division
Roxanne Felix	Alberta Mental Health Board
Doug Fleming	Pembina Hills Regional Division
Verlie Gilligan	Student Health Initiative
Harold Lipton	Alberta Mental Health Board
Sue Ludwig	Alberta Health and Wellness
Jane Manning	Mistahia Health Region
Fern Miller	Alberta Health and Wellness
Barbara Morban	Alberta Learning
Dorothy Ungstad	Region 6 Student Health Partnership
Linda Yargeau	Diamond Willow Child and Family Services Authority

The Consultant would also like to thank the almost 500 individuals who participated in this research either through in-person interviews, focus groups and/or telephone surveys. In particular, the Consultant wishes to thank the eight Partnerships selected for site visits including:

- Southeastern Alberta (Region 2 – Medicine Hat and Area)
- Headwaters (Region 3 – High River and Area)
- Calgary Rocky View (Region 4 - Calgary and Area)
- Region 6 (Red Deer and Area)
- Westview (Region 8 – Edson and Area)
- Edmonton (Region 10 – Metro Edmonton)
- Lakeland (Region 12 – St. Paul and Area)
- Region 13 (Grande Prairie and Area)

PART A: BACKGROUND

SECTION 1: INTRODUCTION

1.1 Background

The Student Health Initiative (SHI), a provincial government initiative launched in March 1999, is one of several initiatives undertaken under the broader umbrella of the Alberta Children's Initiative (ACI). The Student Health Initiative represented a coordinated approach by the provincial partners of Alberta Learning, Health and Wellness, Children's Services and the Alberta Mental Health Board to enhance health and related support services to children with special health needs registered in school programs.

The goal of the Student Health Initiative is to improve access to, and enhance the provision of, integrated health and related support services for children with special health needs so that they can participate fully in their education, attain their potential and be successful learners. Eligible children include those with physical and/or developmental disabilities, neurological disorders, sensory impairments, medical conditions, and/or emotional/behavioural disabilities who are registered in school programs, from Early Childhood Services (ECS) through Grade 12. Services eligible for funding include speech-language therapy, physical therapy, occupational therapy, audiology, respiratory therapy, nursing and emotional/behavioural supports.

A total of $25.6 million annually is allocated to this Initiative. Funding decisions were the responsibility of local "Partnerships" consisting of local representatives of health, education (including school jurisdictions, private ECS operators, private schools, charter schools), mental health and child and family services authorities. In 1999/2000, there were 26 Partnerships delivering services funded under the Student Health Initiative.

1.2 Purpose of the Evaluation

The Student Health Initiative represented a new model through which integrated student health services could be provided at the local level. As this new Initiative generated a significant change in service delivery, an evaluation framework by which the effectiveness of the Initiative could be assessed was developed.

Given that the Initiative has been in place for a relatively short period of time, this evaluation was not intended as a comprehensive assessment of the overall impact(s) of the Initiative. Rather, the evaluation was a means to identify key findings associated with the design, implementation and early experiences of the Student Health Initiative. In this context, therefore, this evaluation should be viewed as a formative, rather than a summative, evaluation of the Student Health Initiative. The key goals of the evaluation, developed in consultation with the Evaluation Committee, were defined as follows:

- *to establish the extent to which the Student Health Initiative was congruent with the Alberta Children's Initiative;*
- *to evaluate the overall design, implementation and support of the Student Health Initiative;*
- *to establish whether the Initiative fostered collaboration, coordination and integration of student health services;*
- *to identify preliminary outcomes of the Initiative in terms of enhancing services provided to children and families.*

1.3 Evaluation Period

This evaluation was designed to provide information that targeted numerous activities associated with the Initiative spanning a considerable period including initial Program design and development (spring 1999), implementation and roll-out (fall 1999), preliminary operations (spring 2000) and Partnership review of their first year of activity (Annual Reports submitted in November-December 2000 covering the period from September 1, 1999 to August 31, 2000).

To meet these objectives, the Evaluation Committee contracted with R.A. Malatest & Associates Ltd. to undertake the evaluation of the Student Health Initiative. The consulting team consisted of staff of R.A. Malatest & Associates Ltd. and Ms. Sandra Woodhead Lyons of Woodhead Lyons Consulting Inc. This evaluation is based on research activities completed during the period from February to December, 2000.

The overall findings of the *Student Health Initiative Evaluation* Project are presented in three reports – this **Summary Report, Consultant's Recommendations** and the **Technical Appendix**. The Technical Appendix includes copies of the survey and data collection instruments, statistical tables and comments provided by parents during telephone surveys.

SECTION 2: RESEARCH METHODOLOGY

2.1 Scope of Work

The Consultant utilized a broad-based approach for this formative evaluation, which incorporated a range of activities. The majority of the data collection activities were completed in the spring and fall of 2000, although the evaluation also included a review of literature and documentation provided as recently as December 2000 (Partnership Annual Reports). To meet the objectives of the *Student Health Initiative Evaluation Project*, the following research tasks were completed:

- **Review of Program documentation and development of an evaluation framework.** Prior to the development of the data collection instruments, the Consultant reviewed documents outlining the Program's design and implementation. As part of this activity, the Consulting team also prepared an evaluation framework detailing evaluation activities, indicators and expected outcomes.
- **Review of Partnership information.** As part of the preliminary evaluation activities, research staff reviewed the Service Plans submitted by the 25 partnerships[1] involved in the Student Health Initiative.
- **Administration of a mail-out survey to all 25 Partnerships.** This survey was designed to obtain the perspective of each "Partnership" regarding the design, implementation, support and impact of the Student Health Initiative. Surveys were returned from 24 of the 25 Partnerships that were sent a survey.
- **Field visits/case study review in eight Partnerships across Alberta.** Researchers visited staff in the following partnerships to ascertain first-hand, the services and outcomes associated with the Student Health Initiative:
  - Southeastern Alberta (Region 2 – Medicine Hat and Area)
  - Headwaters (Region 3 – High River and Area)
  - Calgary Rocky View (Region 4 - Calgary and Area)
  - Region 6 (Red Deer and Area)
  - Westview (Region 8 – Edson and Area)
  - Edmonton (Region 10 – Metro Edmonton)
  - Lakeland (Region 12 – St. Paul and Area)
  - Region 13 (Grande Prairie and Area)

  In undertaking these site visits, research staff completed 83 interviews with service providers, regional partners, school administrators and, where applicable, with individuals representing "non-participating agencies". In addition to these interviews, research staff facilitated four focus groups with regional partners (2), service providers (1) and instructional staff (1). As part of the field visits, more than 110 people participated in an interview and/or focus group discussions.

[1] Originally, there were 25 Partnerships: a new Partnership was established during the course of the evaluation, resulting in a total of 26 current Partnerships.

- **Key Stakeholder Interviews**. A total of 15 interviews were completed with key Student Health Initiative stakeholders including most of the current and past members of the Provincial Working Group (PWG). In addition, interviews were completed with representatives from the Assistant Deputy Minister's (ADM) Steering Committee and Deputy Ministers from Alberta Learning and Children's Services.
- **Telephone Survey of Parents**. To establish the extent to which parents of students with special health needs were aware of the Student Health Initiative, as well as to determine their satisfaction with services provided, the Consultant completed a province-wide telephone survey of 364 parents.
- **Review of Partnership Reports**. In November-December 2000, the Consultant reviewed 13 Annual Reports that were made available for review.

2.2 Data Analysis and Validity of the Findings

Overall, the evaluation of the Student Health Initiative is based on extensive research activities as almost 500 individuals were interviewed as part of the evaluation project. In addition to various "quantitative" research methods (i.e., analysis of Annual Report information, telephone survey of 364[2] parents, etc.), incorporated in the evaluation were extensive qualitative elements including eight site visits and consultation with a broad range of various internal and external stakeholders.

As part of this evaluation process, case profiles were prepared for the eight Partnerships visited by research staff. These case studies were subsequently shared with each Partnership, and the results were generally validated by the Partnership. This process provided further confidence that the synthesis and analysis of collected information by the Consultant were consistent with the opinions and experiences of the Partnerships visited as part of this evaluation project.

2.3 Research Limitations

It should be noted that while the results of the evaluation are based on extensive consultation and research activities, there are some limitations associated with the research findings. Therefore, some caution should be exercised in the interpretations of this report. Caveats include:

- **Limited experiences of the Partnerships**. It should be emphasized that as this was not a summative evaluation, evaluation participants were asked to provide preliminary assessment of outcomes. Given the relatively short length of time that the Initiative has been fully operational in most regions, many individuals noted that it was not possible to evaluate the long-term impact of the Initiative either in terms of operational functionality and/or enhancing student health outcomes.
- **Relatively small sample size for field visits**. Although surveys were administered to all Partnerships, the Consultant was able to undertake only a limited number of site visits. While the eight partnerships visited were selected to be representative of all

[2] Based on the number of completions for the parent survey, the results of the telephone survey component can be considered accurate to a maximum of ±5.1% at the 95% confidence level (19 times out of 20).

partnerships in terms of size, region and composition, it is improbable that the eight sites will be absolutely representative of all 26 Partnerships.

- **Potential for bias among stakeholders/service providers**. Although the research staff made every effort to ensure that the information provided by respondents was unbiased, given the close association of many respondents with their Partnership's activities, the potential exists for respondents to favourably portray the operations of their respective Partnership(s).

Notwithstanding these limitations, the results of the research can be viewed with confidence given the range of individuals contacted (partners, service providers, educators, past and present PWG members), and the completion of both qualitative (focus groups, eight site visits) and quantitative (364 parent surveys) research activities.

2.4 Report Structure

This evaluation report consists of three sections:

Part A: Introduction and Background
Provided in this section is an overview of the Student Health Initiative, evaluation and research activities completed, and an assessment of the reliability of the obtained information.

Part B: Evaluation Findings
In this part of the report, the key findings of the evaluation are detailed, including: discussion of the extent to which the SHI was congruent with the Alberta Children's Initiative, program design, implementation and support issues, assessment of collaboration and partnership, service delivery issues and a preliminary assessment of outcomes.

Part C: Summary and Conclusions
This section provides an overview of the Consultant's overall assessment of the Student Health Initiative.

SECTION 3: HISTORY OF THE INITIATIVE AND ACTIVITIES

3.1 Overview

The Student Health Initiative (SHI) reflects a key goal in the Government of Alberta Business Plan 1999-2002 in that:

> *"children will be well cared for, safe, successful at learning and healthy"*

A key element of the Student Health Initiative is to promote the planning, design and delivery of integrated health and related support services to students with special health needs. To this end, in March 1999, the provincial partners of Alberta Learning, Health and Wellness, Children's Services and the Alberta Mental Health Board launched an Initiative with annual funding of $25.6 million, that was designed to furnish a range of health and related support services to students with special health needs.

This funding was allocated to regional "Partnerships"[3] consisting of representatives from the following organizations:

- public school jurisdictions;
- regional health authorities;
- regional offices of the Alberta Mental Health Board;
- child and family services authorities; and
- other school authorities (i.e., charter schools, private schools, private ECS operators).

Funding was allocated to Partnerships on the basis of total student enrollment weighted by a number of factors. The funds were released only after the partners had joined in a Student Health Partnership and had submitted a Student Health Partnership Joint Service Plan.

It was expected that monies would be "pooled" in that funds would not be distributed piecemeal back to each partner on a per-capita basis and that all partners, irrespective of size, would be involved in decisions relating to the allocation and use of funds. It was also indicated that the additional funding was to be used to enhance current services and/or introduce new services, and that partners would be expected to maintain their 1998/99 levels of expenditure (baseline) on student health services.

Eligible Student Health Services and Costs

The Student Health Initiative allowed for considerable flexibility in the designation of SHI eligible services and costs. In general, eligible service categories[4] were defined as follows:

- speech-language therapy;
- physical therapy;

[3] Initially, there were 25 partnerships although during the course of the evaluation, an additional Partnership was approved, resulting in 26 Partnerships.

[4] For a detailed description of the Student Health Initiative, readers should consult the Student Health Partnership Guide 1999/2000.

- occupational therapy;
- audiology;
- respiratory therapy;
- nursing; and
- emotional/behavioural supports (i.e., psychological, social work, behavioural intervention, etc.).

The SHI funded the direct costs for human resources and services associated with the provision of health services (including direct administrative support costs associated with service delivery). Included in the SHI funding was an administrative component equivalent to 4.5% of the total funding allocation which was to support the administration of the Partnership.

3.2 Program Implementation and Support

Considerable effort was required to access the SHI funding for the 1999/2000 school year. Required activities included the formation of the respective partnerships (organizations had to choose other organizations with which they would "partner"), development of a Service Plan (funding priorities, service emphasis, etc.), and submission of the Service Plan to the Provincial Working Group (PWG) for approval.

To support this process, the Provincial Working Group completed several activities, including:

- provision of six information meetings about the Student Health Initiative held throughout the province in the spring of 1999;
- made available staff from Alberta Community Development to assist as facilitators in the development of the Partnerships and Joint Service Plans;
- establishment of a Student Health Initiative coordinator position to provide further information and support; and
- provision of support documents including the *Student Health Partnership Planning Guide 1999-2000*, and *2000-2001*.

In addition to the formal support, each organization was invited to reach its respective PWG contact (i.e., representatives from Alberta Learning, Health and Wellness, Children's Services, Alberta Mental Health Board) should additional information be required as to how the Student Health Initiative complemented programs and services currently delivered.

3.3 Monitoring and Reporting

Under the Student Health Initiative, each partnership was to submit a results or annual report of the activities completed in the 1999/00 school year to the provincial partners by November 1, 2000. It was expected that the report would contain the following information:

- **Statement of Accountability:** confirming the accuracy contained in the report, as well as an affirmation of the Partnership's commitment to use student health funding only for eligible health services for identified students with special needs;

- **Progress:** a description of the progress made in the implementation of strategies and achievement of goals;
- **Results:** an identification of opportunities to further enhance services as well as challenges associated with the current and future delivery of services under the Student Health Initiative.
- **Financial Summary:** Partnerships were required to complete a standardized form (Form 3) detailing the number of students served in each category, actual costs incurred, administration costs and whether the Partnership recorded a surplus based on actual expenditures.

PART B: EVALUATION FINDINGS

The key findings of the formative evaluation of the Student Health Initiative are presented herein. Key evaluation findings are presented under the following headings:

Section 4: Congruence with the Alberta Children's Initiative
Section 5: Program Design, Implementation and Support
Section 6: Collaboration and Partnership Issues
Section 7: Service Delivery Issues
Section 8: Preliminary Assessment of Outcomes

It should be emphasized that the evaluation findings are based primarily on information obtained in the spring of 2000, and supplemented with additional data obtained from the parent survey (fall 2000) and review of the Partnership Annual Reports available for review as of December 2000.

This evaluation represents a synthesis of the Consultant's findings and observations based on the implementation and preliminary activities of the various Student Health Initiative Partnerships across Alberta.

SECTION 4: CONGRUENCE WITH THE ALBERTA CHILDREN'S INITIATIVE

A key objective of the evaluation was to identify the extent to which the Student Health Initiative was congruent with the broader Alberta Children's Initiative (ACI). The ACI was launched in 1998 and provided the Alberta government and its ministries with a vision, expected outcomes and a policy framework to support the healthy development of Alberta's children.

Under the umbrella of the ACI, the Student Health Initiative represented an inter-ministerial initiative designed to enhance the health of students with special health needs in Alberta educational programs.

To ascertain the extent to which the Student Health Initiative was congruent with the ACI, the consulting team completed interviews with key stakeholders and representatives from eight Partnerships that were selected for site visits, as well as data provided by 24 Partnerships via the Partnership survey. Key findings are presented under the following headings:

4.1 Stakeholder Perceptions of the Congruence with ACI
4.2 Assessment of Inter-Ministerial Collaboration

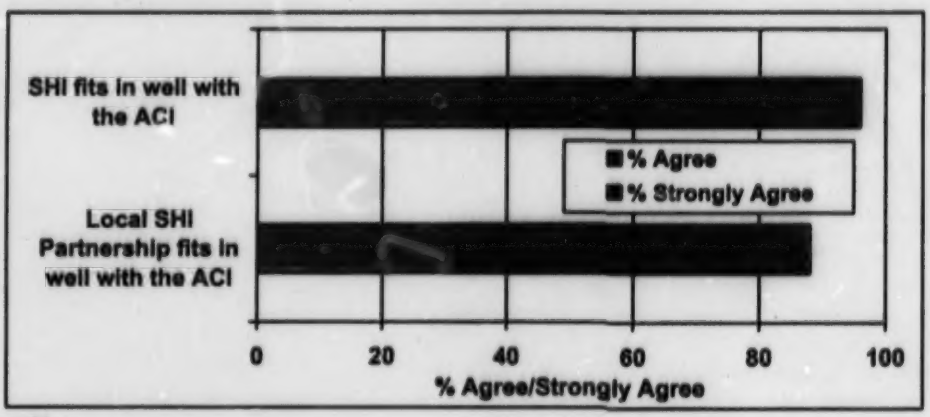
4.1 Stakeholder Perceptions of the Congruence with ACI

Representatives from the Partnerships as well as key internal (PWG) and external (ADM Steering Committee) members were asked to comment on the extent to which the Student Health Initiative was congruent with the ACI. Key findings are detailed below.

Most Stakeholders feel that the Student Health Initiative is congruent with the goals and objectives of the Alberta Children's Initiative.

Overall, the majority of stakeholders and partnerships surveyed were of the opinion that the Student Health Initiative was congruent with the goals and objectives of the Alberta Children's Initiative. For example, as highlighted in Chart 4-1, almost all (96.0%) of the Partnerships noted that the SHI fit in well with the ACI, and a similar high proportion (88.0%) of partnerships noted that their respective student health partnership fit in well with the Alberta Children's Initiative.

Chart 4-1
Partnership Opinion with the Extent to Which the Student Health Initiative was Congruent with the Alberta Children's Initiative



n=24

Key informants were also of the opinion that the Student Health Initiative was consistent with the vision and objectives of the Alberta Children's Initiative. Key stakeholders cited several factors that supported this view, including:

- high level of support for the Initiative, by both middle and senior management in the key departments associated with the Initiative;
- establishment of an inter-ministerial Provincial Working Group (PWG) that allocated considerable time and resources to the Initiative;
- use of collaborative processes at the provincial level to define program objectives and program implementation.

Several stakeholders noted that the Student Health Initiative represented an excellent initiative under the ACI, and that the SHI represented a significant improvement in the delivery of coordinated health services at the local or regional level compared to previous models or approaches.

" ...the SHI was probably one of the best ACI initiatives in that it resulted in greatly improved co-ordination of services at the regional level... it was an "idealistic" program, but it worked!"

-PWG Stakeholder

"... the Student Health Initiative was/is one of the few programs where you have to cooperate to get the funding. Individual organizations have to work together to access the funds."

-PWG Member

The Student Health Initiative has resulted in modest collaboration among partner agencies with other Alberta Children's Initiatives.

In addition to the identification of the extent to which the Student Health Initiative was congruent with the ACI, the evaluation also probed the extent to which the SHI led to increased collaboration with other Alberta Children's Initiatives such as the *Children's Mental Health Initiative*, the *Alberta Partnership on FAS* and *Protection of Children Involved in Prostitution*.

As highlighted in Table 4-1, while more than 90% of partnerships felt that the SHI had fostered increased collaboration with the Children's Mental Health Initiative, there were lower levels of agreement regarding the effectiveness of the Initiative in fostering increased collaboration with other ACI initiatives, such as Protection of Children Involved in Prostitution (8.3%) and the Alberta Partnership on FAS (37.5%).

Table 4-1
Partnership Opinion About the Extent to Which the SHI has Prompted Increased Collaboration With Other ACI Initiatives

Issue	Disagree/ Strongly Disagree	Neutral	Agree/ Strongly Agree	No Opinion/ No Response
Participation in SHI has led to increased collaboration with:				
Children's Mental Health Initiative	8.3%	-	91.7%	-
Alberta Partnership on FAS	41.7%	12.5%	37.5%	8.3%
Protection of Children Involved in Prostitution	58.3%	20.8%	8.3%	12.5%

n=24

Numerous stakeholders noted that there was only limited collaboration with other ACI programs due to the relatively short period of time during which these other initiatives had been underway. Some stakeholders also suggested that while the Student Health Initiative required inter-sectoral coordination in establishing service priorities or funding allocations, there was less of a requirement to establish a similar formal partnership for some of the other Alberta Children's Initiatives such as Protection of Children Involved in Prostitution.

4.2 Assessment of Inter-Ministerial Collaboration

The Student Health Initiative involved representatives from the provincial partners of Alberta Learning, Health and Wellness, Children's Services, and the Alberta Mental Health Board. At the provincial level, the SHI was guided by inter-ministerial committees including the Provincial Working Group (PWG), the ADM Steering Committee and the Deputy Ministers' Committee. The assessment of inter-ministerial collaboration is based primarily on the input gained from interviews with key stakeholders (past/current members of the PWG, ADM Steering Committee, DM members, etc.). The governance of the Initiative at the provincial level was intended to serve as a model for the regional Partnerships. Rather than being the sole responsibility of a line Ministry such as Alberta Learning or Health and Wellness, the Initiative was to be guided by inter-ministerial committees, with issues being resolved either by the PWG, ADM Steering Committee or the DM's Committee. Although the funding was held by Alberta Learning, it was expected that the development and management of the Initiative would be the responsibility of the various inter-ministerial committees.

As a new way of delivering programs and services, the SHI experienced some initial "teething problems".

Partially reflecting the innovative partnership approach, it was not surprising that inter-ministerial collaboration experienced some initial difficulties. Some of the problems identified by stakeholders include:

- **Concern/confusion about program "ownership".** Several stakeholders queried who "owned" or managed the Student Health Initiative. Some individuals noted that because the funding was channeled through Alberta Learning, there was the perception that this project was an Alberta Learning project, rather than a joint cross-governmental initiative. Similarly, PWG members expressed that there was little information as to the role and responsibilities of the members who comprised the Provincial Working Group. Initial confusion as to ownership and responsibilities resulted in some delays by the PWG in developing program guidelines.
- **Problems in defining/determining funding allocations.** Several stakeholders noted that there was considerable confusion regarding the development of the funding model. In addition, some stakeholders felt that there were some "arbitrary" decisions made by Alberta Learning with respect to the funding model (i.e., inclusion of private/charter schools in the development of the funding model). It was noted, however, that in time, the PWG operated in a "partnership" mode, with decisions being made on the basis of input of all partners.
- **SHI required considerable staff time and resources.** Almost all stakeholders noted that the SHI required considerable staff time and resources. Several individuals stated that the Initiative suffered from changes in PWG membership. In addition, PWG members noted that the absence of administrative and project management resources was a barrier to the timely completion of the tasks and activities associated with the Student Health Initiative. It was suggested that a core group of staff assigned or seconded to the Student Health Initiative would have been beneficial.

The decision-making process suggested that the SHI operated as a cross-department initiative rather than as a line department program.

Notwithstanding concerns about responsibilities and staffing, current and former PWG members felt that the decision-making process was generally effective in utilizing inter-ministerial committees (i.e., PWG, ADM Steering Committee, DM Committee) in decision making rather than senior management in the respective line departments.

> *"It was nice to know that decisions were not being made by just Learning or just Health but, rather, by the ADM Steering Committee or DM's Committee on the basis of a "common briefing note" prepared by the Provincial Working Group."*
>
> *-former PWG member*

Overall, most stakeholders felt that the Student Health Initiative was a good model of a cross-government initiative.

Although almost all stakeholders identified a range of deficiencies and problems associated with the start-up of the Student Health Initiative, most stakeholders acknowledged that the SHI was a good model for cross-government initiatives. Among the "best practices" cited by respondents were:

- joint leadership of the Initiative (Learning, Health);
- provision of funding only on the basis of collaboration and agreement of the various "partners";
- decision-making by a cross-government committee rather than line Ministry managers; and,
- the PWG "led by example" using provincial collaboration to support/demonstrate the functionality of a "partnership approach" in providing student health services at the provincial level.

SECTION 5: PROGRAM DESIGN, IMPLEMENTATION AND SUPPORT

As the Student Health Initiative represented a new model by which health services would be delivered to students, an important element of the evaluation was to identify the strengths and weaknesses of the Initiative in terms of design, implementation and support. To this end, several questions regarding program design, implementation and support were included in surveys of stakeholders, partnerships and service providers. Respondents were asked to identify positive implementation strategies (e.g., things that were actually done that worked well), implementation activities that were poorly designed and "omissions" (e.g., things that were not done, but which would have likely enhanced the implementation of the SHI).

Issues addressed in this section include:

- *5.1 Perspectives about the Design of the Student Health Initiative*
- *5.2 Funding Issues*
- *5.3 Satisfaction with Implementation Support*

5.1 Perspectives about the Design of the Student Health Initiative

The Student Health Initiative represented a new model in the delivery of student health services. Rather than the responsibility of a single organization (i.e., Learning or Health), the Student Health Initiative was designed to ensure collaboration in the identification of student health needs and better coordination in the delivery of such services.

Overall, the results of the Partnership surveys suggest that the Student Health Initiative has prompted improved delivery of services to children with special health needs. As detailed in Table 5-1, all Partnerships noted that the SHI resulted in additional incremental programs and services being provided to children with special health needs, and that access to student health services for children had increased.

Table 5-1
Overall Perceptions of the Student Health Initiative Partnership Survey

Factor	Disagree/ Strongly Disagree	Neutral	Agree/ Strongly Agree	No Opinion/ No Response
SHI funding resulted in additional incremental programs and services being provided to children with special health needs.	-	-	100.0%	-
The implementation of SHI has provided increased access to student health services for children.	-	-	100.0%	-
The establishment of the partnership has improved outcomes for students with special health needs.	-	-	95.9%	4.2%
Because of SHI, there is now better coordination of services to children with special health needs.	4.2%	16.7%	79.2%	-

n=24

Notwithstanding the very high levels of support for the Student Health Initiative, a number of issues were identified as problematic. In addition to concerns regarding funding (see Section 5.2) and implementation support (see Section 5.3), evaluation participants noted other issues as being particularly problematic, including:

- **Lack of clearly defined partnership boundaries**. The SHI encouraged organizations to develop their own Partnerships that did not necessarily correspond to existing health and/or education administrative groupings. It was noted that multiple partnerships existed in one health area. While such flexibility encouraged the creation of partnerships that were more likely to reflect the geographic considerations of the local communities, it also created problems in terms of initially defining partnerships (who could partner with what organizations) as well as staffing issues, where health authority staff often participated in two to three partnerships encompassed within the same Regional Health Authority (RHA).

  "I sit as a member of three partnerships for our RHA. I have to do everything three times – once for each partnership. The result is that I spend too much time on administration and not enough on planning and service delivery."

  -RHA regional partner

  "At the start, we spent a lot of time trying to decide who should be included in our partnership."

  -Regional partner

- **Problems associated with a new governance/program delivery model**. The Student Health Initiative required that organizations operate in a "partnership". Numerous regional partners interviewed noted that initially, many of the larger authorities (school jurisdictions, health authorities) had difficulty in adapting to this new model whereby pooled funding was to be used to deliver services identified by a range of both large and small partners. Several regional partners noted that some organizations had difficulty in adjusting to this "partnership" model in terms of identification of service priorities or

program governance. Similarly, due to having a school jurisdiction designated as the "banker", several stakeholders indicated that the large school authorities were initially hesitant to commit to a full collaborative and partner approach in defining service needs and allocating SHI funds.

"School authorities were and still are the strongest members in the Partnership... because they hold the funds, they tended to overshadow other voices/perspectives in our region."
-Regional Partner

"...education representatives feel that they are a stronger/more important partner than the others... it took a long time for them to learn to share decision-making and the dollars."
-Regional Partner

- **Uncertainty as to whether funds were to be pooled or could be re-distributed among partners.** Although the 1999/2000 Planning Guide stated that:

  ...the funding must be pooled and used as a shared resource by the student health partnership...[6]

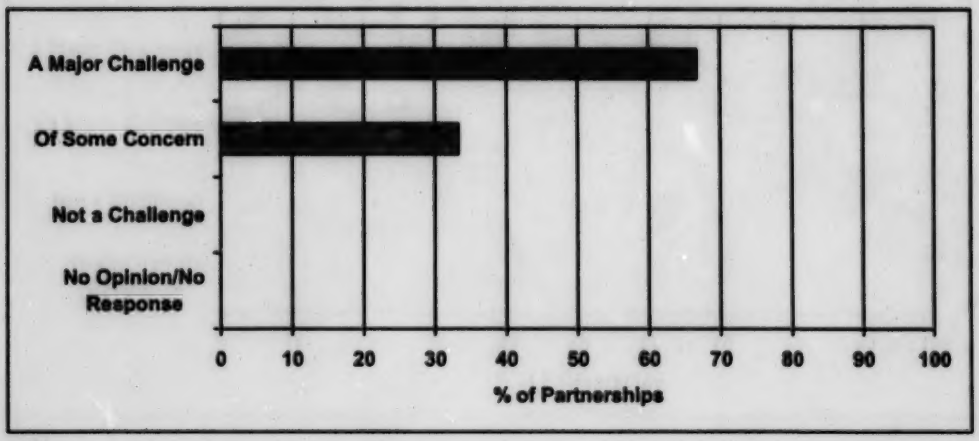
  there was some confusion among some regional partners as to whether the funding could be re-allocated on a per-capita basis back to individual partner organizations. The manner in which the funding allocation was presented (i.e., contribution of each relevant school or school authority) suggested to some organizations that each partner was entitled to a "share". Numerous stakeholders and evaluation participants expressed that this issue was a key discussion point in many initial Partnership meetings. An example of such comments follows:

  "... we spent a lot of time at the start trying to establish how the money was to be allocated... many of the larger school district partners felt that the funding should be allocated on a district by district basis which went against the pooled resource concept..."

- **Lack of time to develop partnerships/Joint Service Plan.** A consistent criticism of the Student Health Initiative was the requirement to complete a range of activities within a very short period of time. With the announcement of the Initiative in the spring of 1999, regional partners had only three months to form partnerships, complete any required needs assessment(s) and submit a Joint Service Plan to the PWG. As highlighted in Chart 5-1 below, the time required to form partnerships was identified as a major challenge by two-thirds (64.0%) of partnerships and was of some concern to one-third (32.0%) of partnerships.

[6] Student Health Partnership Planning Guide: 1999/2000, p.5

Chart 5-1
Extent to Which Time Required to Form Partnership was a Major Challenge or of Some Concern



n=24

- **Government reporting requirements.** Many partners noted that completion of the Joint Service Plan and other reporting requirements (i.e., Annual Report, etc.) represented significant time and resources for the Partnerships. Partnerships noted that it was particularly difficult to identify current or base level expenditures for student health services. In the partnership survey, more than three-quarters of partnerships indicated that government reporting requirements were a major challenge (33.3%) or of some concern (58.3%). Only 4.2% of partnerships indicated that reporting requirements were "not a challenge".

5.2 Funding Issues

While almost all evaluation participants noted that the additional $25.6 million annually available under the Student Health Initiative had improved the ability to provide additional services to children with special health needs, issues associated with funding generated considerable comment as detailed below:

Many partners questioned the funding formula used to derive base funding allocations.

A number of regional partners noted that they had very little information as to how SHI funding was derived for the partners and/or partnership. Several individuals also noted that the base funding allocations were partially based on the number of students with mild/moderate disabilities - classifications which traditionally have not been submitted to Alberta Learning on a comprehensive or systematic basis.[7] In this context, some partners felt that they received less than their "fair share" of SHI funding.

[7] Stakeholders noted that coding for students with mild/moderate disabilities was not uniform across school authorities.

Partnerships operating in remote/rural regions also noted that the cost to operate and provide student health services would be higher than costs associated with service delivery in urban Partnerships. Several individuals expressed that the SHI funding model should reflect the cost differences associated with operation of Partnerships (i.e., travel time to attend meetings to provide services to students who were dispersed over a wide geographic area, etc.) as well as the difficulty in providing student health services in rural/remote regions (see section 7.2 for a discussion of these issues).

Almost all partners cited concerns about inadequate funding for administration-particularly for start-up/implementation.

Almost all Partnerships (95.9%) indicated that the lack of funding for administrative costs during partnership development was a major challenge (79.2%) or of some concern (16.7%). Only one of the 25 Partnerships felt that there was adequate financial resources available to help the partnership during the planning stage.

While some partners felt that funding allotment (4.5% of the total funding allocation) would be sufficient to cover administration costs once the partnership had reached an "operational stage", few partners felt that the additional one-time 5% start-up allocation was adequate to cover the considerable costs associated infrastructure (i.e., telephone, computers, etc.) and other start-up costs. Review of a number of the Annual Reports submitted by the Partnerships suggest that partners committed considerable time and resources to this Initiative. For example:

> *"The Partnership was significantly affected by a low administration budget for planning, evaluation, reporting and consultation with the public. As a result, the partners had to commit their own resources initially."*
>
> *- Partnership Annual Report*

Some partners reported that the time and resources expended on start-up and initial administration was two to three times the amount allocated under the SHI funding model.

Irrespective of size, each Partnership noted the need to provide sufficient funds for a coordinator position.

Due to the extensive reporting and administrative requirements associated with the Student Health Initiative, many of the smaller partnerships noted that they did not have sufficient resources to hire a coordinator on a full-time basis. While larger partnerships generally hired a coordinator, smaller partnerships required staff to undertake these activities as part of their existing job duties, and/or hired contract staff to assist in administrative activities. It was indicated that each Partnership should have received funding to hire at least one coordinator (at a minimum .4 to .5 FTE) to assist in the start-up, design and implementation of the Partnership.

Partners cited concerns about non-funded costs.

Several partners cited concerns about costs that were not funded under the SHI. Typical concerns included:

- additional costs for space to accommodate new staff;
- capital costs associated with upgrading facilities;
- costs of secretarial and/or accounting services; and
- computers, phone lines, other communications.

While some partnerships noted that they received some assistance from Alberta Infrastructure, many partnerships noted that these services/costs were being borne by the major partners.

Issues associated with the sustainability of the initiative

In addition to completion of numerous interviews and detailed case studies, the research team also reviewed the Annual Reports submitted by the Partnerships. This review included an analysis of data from 13 Annual Reports that were available for review by the Consultant. Of the Annual Reports that the Consultant was able to review, most indicated that their respective Partnership was in a surplus position as of August 31, 2000.

Many Partnerships noted that their surplus was due in large part to the inability to hire sufficient staff during the initial implementation of the Initiative. In many of the Annual Reports, it was noted that it was unlikely that this surplus would exist in the future as Partnerships filled vacant positions.

Some Partnerships noted the need for long term funding which could affect the future delivery of services. For example, several Partnerships stated that their current budget did not include any allowances for cost of living increases or wage settlements which would result in increased costs and/or necessitate reduction in services. It was noted that future SHI funding should include allowances for increased staff costs and inflation.

In addition to concerns about cost, several individuals noted that it would be important for the SHI to be seen as a long-term initiative. For example, some stakeholders noted that the funding model should be moved to a "three year rolling model" to ensure that partners would be comfortable in the certainty of long term funding.

> *"... to recruit and retain staff, they need to know that their positions will continue to be funded after the end of 2002."*
>
> *-Regional partner*

5.3 Satisfaction with Implementation Support

To support the launch and implementation of the Student Health Initiative, the Provincial Working Group (PWG) made numerous supports available to the Partnerships, including:

- Information meetings in April 1999 (Calgary, Lethbridge, Edmonton, Red Deer, Grande Prairie, St. Paul)
- Student Health Partnership Planning Guide (1999/2000)
- Student Health Initiative – Matrix of Authority boundaries (attached to Planning Guide)
- List of Charter Schools, Private Schools, Private ECS operators (attached to Planning Guide)
- Access to facilitation services from Alberta Community Development
- Access to the full-time Provincial Coordinator for the Student Health Initiative
- Access to the Provincial Working Group
- Access to the Student Health Initiative Web Site - Questions and Answers
- Review of Joint Service Plans - review summary provided by PWG
- FOIP Bulletin

The majority of partnerships were satisfied with the level of government support

As detailed in Table 5-3, Partnerships had varying opinions about the usefulness of available resources. For example, while Partnerships found the list of schools and the Planning Guide to be helpful or very helpful, relatively few (29.2%) Partnerships were satisfied with the services provided by Alberta Community Development[8]. Summarized in Table 5-3 are the resources provided to the partnerships by the Provincial Working Group, and the perceived usefulness of each resource.

[8] Several individuals noted that because Alberta Community Development staff were neither familiar with health or education programs/policies, they were of only limited benefit in initial Partnership consultations and meetings.

Table 5-3
Resources Provided by the Provincial Working Group

Resource	Unhelpful/ Very Unhelpful	Neutral	Helpful/ Very Helpful	No Opinion/ No Response
List of Charter Schools, Private Schools, Private ECS Operators	-	12.5%	87.5%	-
Student Health Partnership Planning Guide	-	8.3%	87.5%	-
SHI – Matrix of Authority Boundaries	-	16.7%	79.2%	4.2%
Access to full-time Provincial Coordinator for the SHI	4.2%	16.7%	79.1%	-
FOIP Bulletin	4.2%	16.7%	75.0%	4.2%
Information meetings in April 1999	8.4%	20.8%	66.7%	4.2%
Review of Joint Service Plans	8.3%	20.8%	66.6%	4.2%
Access to the SHI Web Site – Questions and Answers	16.7%	29.2%	50.0%	4.2%
Access to the Provincial Working Group	4.2%	37.5%	45.9%	12.5%
Access to facilitation services from Alberta Community Development	33.3%	33.3%	29.2%	4.2%

n=24

In addition to commenting on the various supports, Partnerships were asked to comment on the support provided by the PWG in facilitating the establishment, planning processes and overall development of the Partnership. The key findings are detailed below.

Overall, the majority of Partnerships were satisfied with the support provided by the Provincial Working Group.

In general, with the exception of the provision of adequate financial resources, most Partnerships were satisfied with the support provided by the Provincial Working Group. As highlighted in Chart 5-3, there was considerable support cited with respect to information resources provided (64.0% of Partnerships indicated such resources were helpful or very helpful) and the overall support provided by the PWG (56.0%).

> *"We found the Planning Guide to be very helpful – we almost have them memorized by now"*
> *-Regional Partner*

> *"Initially, it was difficult to get information from the PWG – hiring of the coordinator made a big difference."*
> *-Regional Partner*

Table 5-3
Resources Provided by the Provincial Working Group

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Access to the Provincial Working Group	4.2%	37.5%	45.9%	12.5%
Access to facilitation services from Alberta Community Development	33.3%	33.3%	29.2%	4.2%

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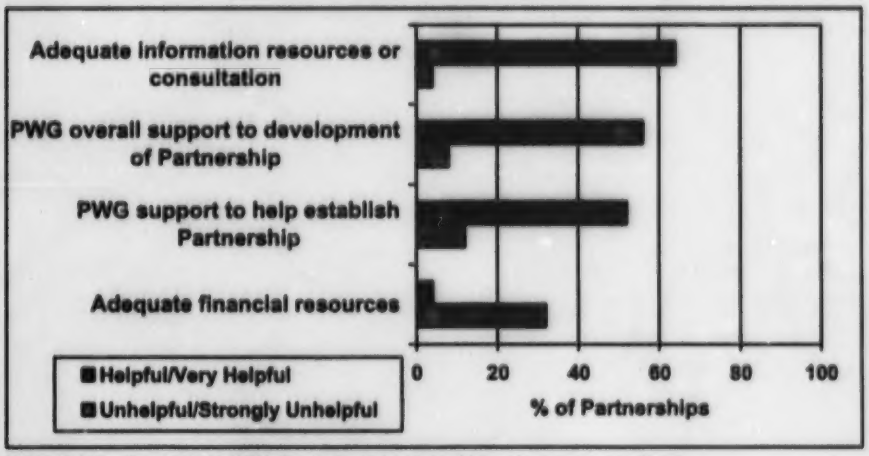
> *"We found the Planning Guide to be very helpful – we almost have them memorized by now"*
> *-Regional Partner*

> *"Initially, it was difficult to get information from the PWG – hiring of the coordinator made a big difference."*
> *-Regional Partner*

Chart 5-3
Partnership Opinions Regarding Helpfulness of Government/PWG Supports



Note: Totals will not add to 100% due to neutral and don't know responses not shown.
n=24

Regional Partners provided several suggestions as to how the PWG could have enhanced the roll-out and implementation of the Student Health Initiative.

Overall, while most Regional Partners were satisfied with the support provided by the PWG, there were several suggestions as to how the PWG could have better supported the launch and implementation of the Student Health Initiative, including:

- **Opportunities/mechanisms for Partnerships to share information/experiences.** Several regional partners noted that it would have been beneficial to share information between Partnerships with respect to design and early implementation. Specifically, a conference or workshop would have been useful. Other individuals suggested that the PWG establish a web "bulletin board" through which partners/partnership coordinators could share information.
- **Ensure adequate resources exist.** Numerous Partnerships noted that while the SHI provided additional funding for health service professionals, there was insufficient supply of such professionals. Several Partnerships felt that the PWG should have anticipated demand for such professionals and tried to ensure that sufficient professionals would have been available when funds were released.
- **Establishment of "Implementation Teams".** Most Partnerships were supportive of the role of the Provincial Coordinator, but several Regional Partners noted that the implementation could have been better facilitated by having more full-time dedicated resources to support the formation of the Partnerships. It was suggested that the PWG should have made available one to two implementation "teams" to assist in the formation of the partnerships and development of the initial Joint Service Plans.

SECTION 6: COLLABORATION AND PARTNERSHIP ISSUES

A key goal of the Student Health Initiative was to encourage health, educational and children's service organizations to adopt a collaborative and coordinated approach in the delivery of student health services. The establishment of a "Partnership" also required changes in the management and delivery of student health services.

Issues addressed in this section include:

6.1 Opinions as to the Effectiveness of the Partnership Model

6.2 Views About Partnership Collaboration and Service Coordination

6.3 Inclusion of Children, Families and Community Members in the Planning Process

6.1 Opinions as to the Effectiveness of the Partnership Model

The evaluation team spent considerable time reviewing the partnership models to ascertain the effectiveness and functionality of the Partnership Model. The key findings have been highlighted below:

Most Partnerships reported that they had reached a stage where the Partnership was "functional" in terms of governance, needs assessment and accountability.

As highlighted in Table 6-1, the majority of the Partnerships surveyed felt that their Partnership was functional in terms of governance, needs assessment and accountability. For example:

- 96.0% of Partnerships felt that there was a commitment to the Partnership agreement amongst all partners;
- 88.0% of Partnerships indicated that an effective decision-making process had been established; and,
- 88.0% of Partnerships agreed that there were appropriate accountability mechanisms in place.

Table 6-1
Opinions As to the Effectiveness of the Partnership Model
Selected Issues

Area	% Disagree / Strongly Disagree	% Neutral	% Agree / Strongly Agree	% Don't Know / No Response
Commitment to the Partnership agreement among all Partners.	-	-	96.0%	4.0%
There is an effective planning process in place.	4.0%	-	92.0%	4.0%
There is an effective communication between partners.	4.0%	4.0%	88.0%	4.0%
There are appropriate accountability mechanisms in place.	4.0%	4.0%	88.0%	4.0%
An effective decision-making process has been established.	8.0%	-	88.0%	4.0%
There is a process for establishing priorities.	16.0%	8.0%	64.0%	12.0%
There is an effective means of conflict resolution.	12.0%	24.0%	60.0%	4.0%

n=24

Despite the positive assessment of the current status of the Partnerships, many participants noted that development of the Partnership models required considerable time and resources.

> *"...Time was the biggest barrier. Everything takes so much collaboration, which is very time consuming. There was definitely a personal cost."*
>
> *-Regional Partner*

> *"Size was a factor. It was difficult for all partners to all come together."*
>
> *-Regional Partner*

> *"There was not always consensual agreement - issues had to be discussed, addressed and eventually were resolved...but it took time - lots of it."*
>
> *-Regional Partner*

6.2 Views About Partnership Collaboration and Service Coordination

Overall, the results of the evaluation suggest that the SHI has served as a catalyst to enhance collaboration between various partner organizations in delivering student health services. As highlighted in Chart 6-2A, more than three-quarters of the Partnerships noted that the SHI enhanced the sharing of information between partners (92.0% of partnerships reported an improvement or significant improvement in this area), as well as improvements in the area of planning (88.0%) and decision-making (88.0%). In addition, two-thirds (68.0%) of Partnerships noted that there had been an improvement in terms of collaborating on pooled funding.

Table 6-1
Opinions As to the Effectiveness of the Partnership Model
Selected Issues

Area	% Disagree / Strongly Disagree	% Neutral	% Agree / Strongly Agree	% Don't Know / No Response
Commitment to the Partnership agreement among all Partners.	-	-	96.0%	4.0%
There is an effective planning process in place.	4.0%	-	92.0%	4.0%
There is an effective communication between partners.	4.0%	4.0%	88.0%	4.0%
There are appropriate accountability mechanisms in place.	4.0%	4.0%	88.0%	4.0%
An effective decision-making process has been established.	8.0%	-	88.0%	4.0%
There is a process for establishing priorities.	16.0%	8.0%	64.0%	12.0%
There is an effective means of conflict resolution.	12.0%	24.0%	60.0%	4.0%

n=24

Despite the positive assessment of the current status of the Partnerships, many participants noted that development of the Partnership models required considerable time and resources.

> *"...Time was the biggest barrier. Everything takes so much collaboration, which is very time consuming. There was definitely a personal cost."*
>
> *-Regional Partner*

> *"Size was a factor. It was difficult for all partners to all come together."*
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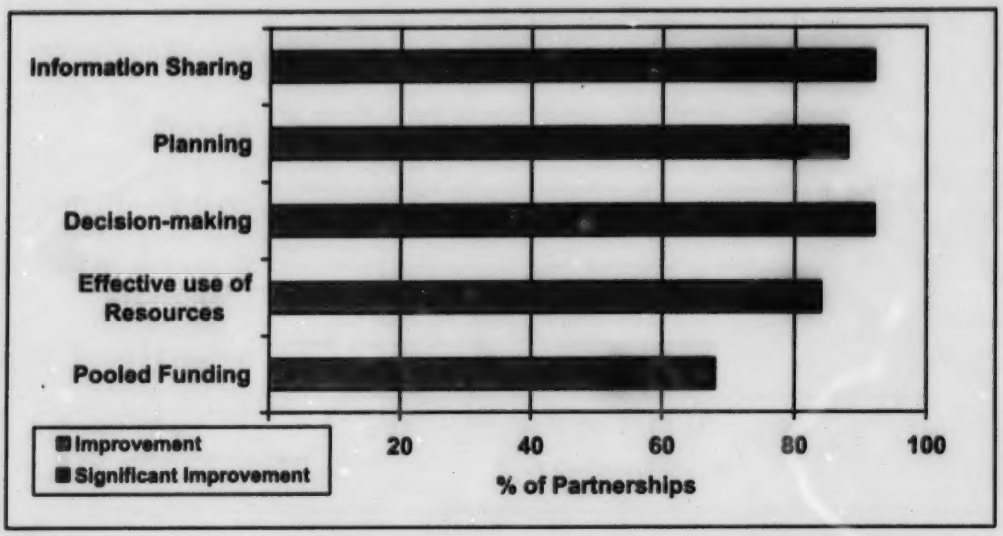
Chart 6-2A
Improvements at the Individual Partnership Level

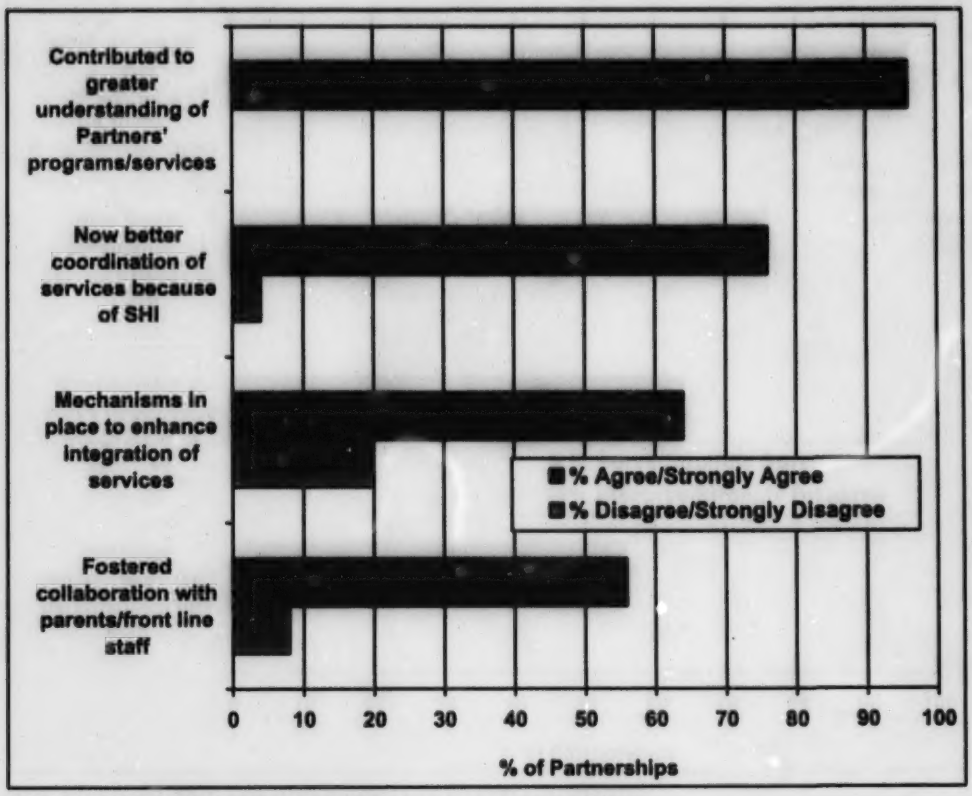


n=24

Regional partners, service providers and parents feel that the SHI has contributed to better coordination of services.

Overall, it appears that the Student Health Initiative has resulted in better coordination of health services. As highlighted in Chart 6-2B, the majority of Partnerships agreed or strongly agreed that the Initiative enhanced the understanding of the programs/services offered by the respective partner organizations (96.0%), and that the SHI has resulted in better coordination of services (76.0%).

Chart 6-2B
Partnership Opinion with Respect to Service Coordination Issues



Note: Totals do not add to 100% as neutral/don't know responses are not shown.
n=24

In addition to the positive assessment by the Partnerships, the results of the telephone survey of parents suggest that a majority of parents also feel that services are better coordinated. For example, almost two-thirds of parents (62.9%) agreed or strongly agreed that the health and education staff helping their child were "working together".

Evaluation participants cited several examples as to how services were being better coordinated:

- establishment of a central referral or coordinating centre for student health services. Several partnerships had established referral processes/protocols to help ensure that services were not being duplicated.
- enhanced ability to complete case conferencing. Several service providers noted that due to increased staffing levels, there was a greater opportunity for case conferences with parents, teachers and other health professionals.
- creation of multi-disciplinary teams to deliver services using a coordinated approach.
- better reporting and communication between service providers.

6.3 Inclusion of Children, Families and Community Members in the Planning Process.

In addition to creating partnerships that included regional partners and service delivery agencies, it was hoped that the Student Health Initiative would foster greater "community" input into the planning and delivery of student health services. The key evaluation findings are presented below:

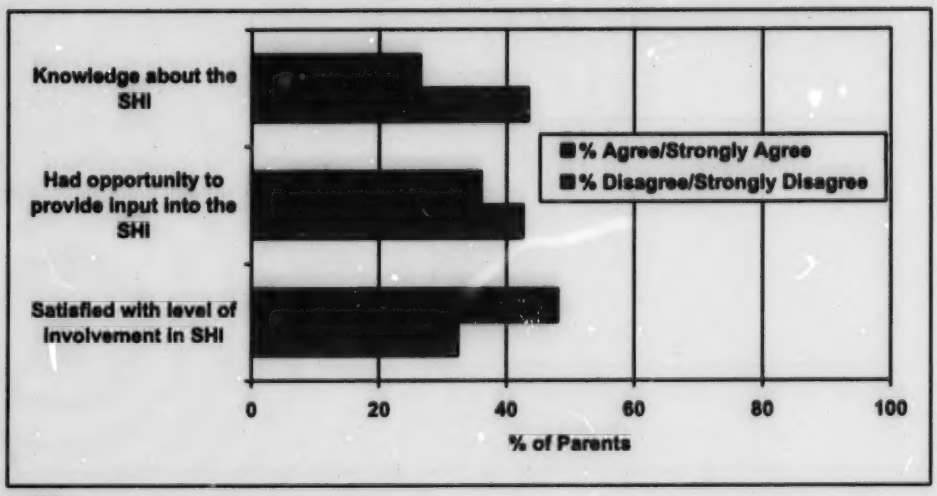
Overall, the results of the evaluation suggest that Partnerships have made only limited progress in fostering community/parental involvement.

Less than one-third (32.0%) of Partnerships felt that there was sufficient involvement of children, families and community members within the partnership. Similarly, a significant proportion of Partnerships noted that the lack of understanding of the Student Health Initiative was a major challenge (cited by 12% of Partnerships) or of some concern (64.0%) among parents.

The Parent Survey confirmed that most parents had little knowledge of the Student Health Initiative and only limited opportunity to provide input into the SHI Partnership. As depicted in Chart 6-3, fewer than one-half of parents surveyed indicated that they were knowledgeable about the Student Health Initiative or that they had opportunity to provide input into the SHI Partnership.

It should be emphasized that while parents were generally not knowledgeable about the Student Health Initiative, very few (33%) were dissatisfied with their level of involvement in the Student Health Initiative.

Chart 6-3
Parental Satisfaction with their Knowledge, Opportunity to Provide Input, and Level of Involvement with their Local Student Health Initiative Partnership



n=364

Evaluation participants cited lack of time and time commitments as barriers to parental involvement.

Many of the evaluation participants expressed that because the Joint Service Plan had to be submitted to the government within a very short period of time, there was limited opportunity to solicit parental input. It should be noted that a number of Partnerships did complete some activities (surveys, town hall meetings, meetings with school councils, etc.) to try to incorporate parental and community input, but these activities had only limited success.

Several participants stated that due to the significant time requirements associated with attending the planning meetings, few parents were able to participate fully in the Partnership.

> *"...we had invited 2 to 3 parents to sit in and be involved in the development of the Partnership...however, the time commitment was too onerous and their attendance was sporadic..."*
>
> *-Regional Partner*

SECTION 7: SERVICE DELIVERY ISSUES

As part of the evaluation process, the Consulting team explored issues related to the delivery of services funded under the Student Health Initiative. Information in this section is based on the synthesis of data from a variety of sources including the Partnership Survey, site visits, Parent Survey and review of the Annual Reports submitted by 13 Partnerships. Based on a review of the information, the following key service delivery themes will be addressed:

7.1 Service Delivery Approaches Developed
7.2 Rural/Remote Service Delivery Issues
7.3 Staffing Issues
7.4 Monitoring and Evaluation Activities
7.5 Program Expenditures

7.1 Service Delivery Approaches Developed

Based on the eight site visits, as well as review of the Annual Reports submitted, it appears that Partnerships have adopted a range of approaches in the delivery of services funded under the Student Health Initiative. In general, the Consultant has defined four service delivery "approaches" although, in practice, many of the Partnerships utilize a mix of all four approaches. In many instances, the model or approach utilized reflected the funding available and/or the service delivery structure of the existing service providers.

In general, classification of the delivery approaches can be described as following:

- establishment of stand-alone service centre(s)/resource team(s);
- enhancement of existing services (augmentative approach);
- establishment of new services, and,
- partner purchase of additional services.

It should be emphasized that these models are not mutually exclusive, as many Partnerships would be characterized by using all four approaches as described below:

Establishment of stand-alone service centres/resource teams

In several partnerships, the SHI funding resulted in the establishment of a stand-alone centre or resource team of health professionals. In this model, health professionals were not attached to any particular school division or area, but provided services on a priority basis. Such models generally required the establishment of a referral system and the "marketing" of the team/centre to educators and parents. Due to the significant costs associated with operation of such "stand-alone" centres, this mode of service delivery was generally found in the larger partnerships, although several smaller Partnerships noted that they had formed resource teams of associated health professionals.

Enhancement of existing services (augmentative approach)

Many Partnerships indicated they would channel additional resources to augment existing student health services. Under this model, respective service providers (i.e., Regional Health Authority, Alberta Mental Health Board, etc.) would be funded to hire additional staff (i.e., speech language pathologists, children's mental health therapists, etc.) to enhance existing service delivery. In these models, Partner agencies used existing referral processes to allocate cases to new staff. Almost all Partnerships visited allocated a portion of their SHI funding to augment existing health services.

Establishment of new services

The provision of additional funds under the Student Health Initiative also allowed for some regions to establish services that were not typically available in schools in the past. For example, some Partnerships allocated funds to the Mental Health Board to hire children's therapists to work in the schools.

Partner purchase of additional services

In some Partnerships, the service delivery model included the transfer of funds to Partner agencies (typically school divisions or authorities) to purchase specific services. In this model, the Partnership devolved much of the responsibility of service priorities to schools and/or school authorities. Typically, partner agencies would use such funds to purchase consulting services and/or staff new positions such as speech assistants and/or family-school liaison workers.

It should be emphasized that it was not within the scope of this evaluation to assess the appropriateness of the various service delivery models. Identification of these delivery models do, however, serve to illustrate the broad range in which Partnerships have developed programs/services to establish student health services funded under the Student Health Initiative.

7.2 Rural/Remote Service Delivery Issues

During the site visits, it was noted that while the Student Health Initiative used a common or standard funding formula, the cost of service delivery varied considerably for rural/remote Partnerships as compared to concentrated urban partnerships.

Regional Partners in geographically large regions identified several factors that affected their ability to design, plan and deliver quality health service under the Student Health Initiative. These include:

- difficulty in convening planning meetings in which partners must travel long distances to attend meetings;
- difficulty in completing adequate testing and assessment as specialists must spend considerable time in travelling to the various communities;
- limited ability to establish centralized services. Due to the considerable travel distances required to serve the entire Partnerships, representatives in large

rural/remote regions noted that establishment of a resource centre to be used as a "pooled resource" was not an option. In this context, many rural/remote Partnerships decided not to create specialized student health services that would be more common in urban partnerships.

Numerous stakeholders from rural/remote Partnerships indicated that they felt that the Student Health Initiative should explicitly recognize the higher cost of service delivery associated with service delivery in rural/remote Partnerships. In addition to higher allocations for administration, the Partnerships also noted that they should receive higher per-student funding to partially offset the higher costs of service delivery.

> *"There is currently an inequity in the funding model. 10 hours of funding in a rural setting will not cover as many students as 10 hours of funding in an urban setting."*
>
> *-Regional Partner*

7.3 Staffing Issues

It became evident early in the evaluation that most, if not all, Partnerships were experiencing difficulties in recruiting health professionals. Most organizations noted the sudden demand for staff completely outstripped the available supply. More than one-half (58.3%) of Partnerships noted that the lack of human and other resources was a "major challenge" in the implementation of their service plan, and a similar proportion (54.2%) reported the limited availability of qualified front-line staff as a "major challenge".

Rural Partnerships noted that staffing their newly created positions was particularly problematic. One Regional Partner commented,

> *"...we had our one SHI position (OT) turn over three times over a six month period - it was like our staff were going to the highest bidder..."*

Based on a review of provided Annual Reports, it appears that staff shortages remain an issue for many of the Partnerships. As detailed in Table 7-1, staff shortages were not unique to the smaller Partnerships, as large Partnerships (defined as those that received $1 million or more in SHI funding) also experienced difficulty in filling planned positions.

Table 7-3
Staff Shortages by Partnership
(Small and Large Partnerships)

Partnership Size (based on SHI funding)	Number of Partnerships	Planned SHI FTEs	Actual FTEs Filled	% Difference
Large (SHI ≥$1 million)	4	169.9	138.2	-18.7%
Small (SHI <$1 million)	9	84.7	76.8	-9.3%
Total	13	254.6	215.0	-15.6%

Source: Annual Reports

It should be noted that the 15.6% deficit in positions filled relative to planned positions actually understates the human resource difficulties faced in many Partnerships. For example, in analyzing human resource issues, many Partnerships noted that - due to

difficulties in hiring qualified professional staff - they resorted to hiring "para-professional staff". For example, in many regions, Partners reported that because of difficulties in hiring Speech Language Pathologists, they had instead hired Speech Language Assistants. Similarly, some Partnerships reported hiring family school liaison workers to assist mental health therapists.

7.4 Monitoring and Evaluation Activities

At the time of the field visits and Partnership Surveys, most Partnerships were just beginning to establish internal monitoring and evaluation activities. Review of the 13 Annual Reports indicated that while all Partnerships are planning to undertake some evaluation activities, there is a considerable range in evaluation approach and activities. For example, whereas some Partnerships have established performance targets and implemented data collection activities to establish whether the targets have/will be met, other Partnerships have noted that they will be completing "self assessments" to ascertain the effectiveness of their program delivery.

Many Partnerships have noted that they plan, or have recently completed, surveys of parents, schools and children to establish client satisfaction with services provided.

7.5 Program Expenditures

Cursory analysis of the Annual Reports provided to the Consultant suggests that actual SHI expenditures in the first year have been below initial expectations. Most Partner organizations cited the following reasons for the current surplus:

- inability to establish programs/priority areas until well into the 1999/2000 school year;
- difficulty in recruiting and filling new staff positions;
- difficulty in accessing testing and consulting services.

As not all Partnerships provided financial information (Form 3) in their annual report, information presented in Table 7-2 is based on 11 Partnerships. As highlighted in the Table, based on the 11 Partnerships that provided information, it appears that Partnerships have expended only one-half of their targeted expenditures in the first year of the Student Health Initiative. As detailed in the Table, the surplus among larger Partnerships (57.3% of planned expenditures) was larger than that of the smaller partnerships (37.2%) which is consistent with the higher proportion of unfilled staff positions reported for the larger Partnerships.

Table 7-5
Planned and Actual Program Expenditures - 1999/2000

Partnership Size	Number	Planned Budget ($m)	Actual Expenditures ($m)	Surplus ($m)	Surplus as a % of Planned Budget
Large (SHI ≥$1 million)	3	8.36	3.57	4.79	57.3%
Small (SHI <$1 million)	8	3.87	2.43	1.44	37.2%
Total	11	12.23	6.00	6.23	50.9%

Source: Annual Reports

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Source: Annual Reports

SECTION 8: PRELIMINARY ASSESSMENT OF OUTCOMES

Although intended to be primarily a formative or process evaluation, some information was collected with respect to some preliminary outcomes associated with the Student Health Initiative.

Assessment of outcomes is based on three lines of evidence:

- Field research/survey conducted in the spring of 2000;
- Telephone survey of parents completed in the fall of 2000;
- Review of Annual Reports submitted in November-December of 2000.

Information in this section is presented as follows:

8.1 Preliminary Identification of Outcomes Associated with the Student Health Initiative

8.2 Identification of Unmet Needs

8.3 Overall Assessment of the Student Health Initiative

8.1 Preliminary Identification of the Outcomes Associated with the Student Health Initiative

Evaluation participants, regional partners, service providers and parents identified a range of positive outcomes associated with the Student Health Initiative. It should be emphasized, however, that much of this assessment is based on only limited information.

Evaluation participants have indicated that the SHI has resulted in both quantitative and qualitative improvements in the delivery of health services to children.

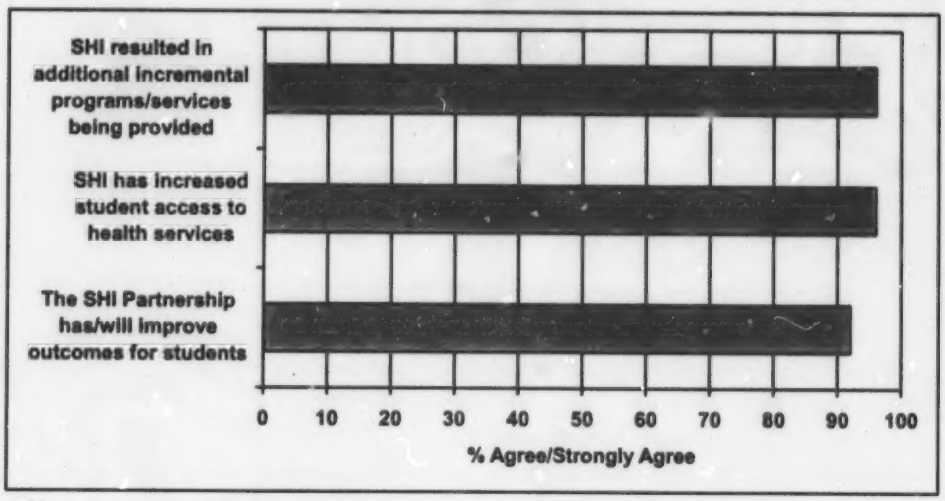
Evaluation participants cited numerous examples as to how the Student health Initiative has resulted in improved student health services for children. In general, the positive outcomes can be classified as follows:

- Enhancements in Existing Services. Many regional partners and service providers noted that the additional SHI financing allowed the Partnership to enhance current services. Typically, this meant that Partnerships hired more student health professionals in existing categories/classifications. Service providers indicated that these additional services allowed them to see more children, as well as to spend more time with each child. Other positive outcomes included more time to do case conferencing as well as develop more comprehensive Individualized Program Plans (IPPs) for each child.
- Introduction of "New" Services. Several Partnerships noted that the SHI funding had allowed them to provide "new" student health services that were not previously readily available. Among these included new assistant positions (Speech Language Assistants, Family School Liaison Workers, etc.) as well as new "specialist" positions such as Behavioural Consultants, psychologists, alternative communication specialists, etc. Many Partners noted that such positions would not have been established in the absence of Student Health Initiative funds.

- Targeting of Services to New Client Populations. In discussions with the regional partners and service providers, it was noted that the SHI funding facilitated the expansion of programs and services to populations traditionally under-served or not at all served. Examples include the provision of more/new services to student populations (junior and senior high schools) that, in the past had received only minimal services.

Information collected in the field visits and Partnership Surveys in the spring of 2000 suggests that the Partnerships had already experienced early, positive results. As detailed in Chart 8-1A, more than 90% of the Partnerships agreed or strongly agreed that the SHI had increased the level of services, access to services, and had greatly improved outcomes for students.

Chart-8-1A
Partnership Assessment of the Outcomes Associated with the Student Health Initiative



n=24

Regional partners, service providers and school staff provided considerable anecdotal information as to how the Student Health Initiative had improved service delivery. A sample of such comments have been provided below:

> *"Therapy was a service unheard of before, unless the family purchased the services privately. Now we can offer the service to students and their families either at school or at their home."*
>
> *-Service provider*
>
> *"My staff are very positive and excited about the new services that are available. I see a lot more health service staff in my school."*
>
> *-School principal*

"For the first time, we can now provide services to children with mild to moderate disabilities, not just the high needs students."

-Service provider

Parents identified several positive outcomes associated with the introduction of the Student Health Initiative.

Although the Parent Survey was established to collect baseline information about the Student Health Initiate to facilitate a summative evaluation, several questions were included in the Parent Survey to ascertain whether parents had observed any changes in service delivery.

As highlighted in Table 8-1, the majority of parents surveyed indicated that they had noted improvements in several areas including opportunities for the child to actively participate in school activities (57.4% of parents agreed or strongly agreed), student achievement (65.2%) and to better able to meet goals (57.4%). In contrast, a lower proportion of parents (39.3%) felt that their child's attendance at school had improved[5].

Table 8-1
Parental Perceptions with Respect to Changes in Services
Parent Telephone Survey

Issue	Disagree/Strongly Disagree	Neutral	Agreed/ Strongly Agree	No Opinion
Overall, my child's achievement in school has improved	13.3%	14.8%	65.2%	6.7%
My child has more opportunities to actively participate in school activities	10.8%	20.0%	57.9%	11.9%
My child is now better able to meet goals set for them	14.4%	8.1%	57.4%	20.0%
My child's attendance at school has improved	13.7%	28.9%	39.3%	18.1%

n=270 (only those parents with children who received services primarily in school)

It should be noted that although the Student Health Initiative has allowed Partnerships to target additional services to older students, parents with children in junior high (Grades 7-9) or senior high (Grades 10-12) schools were less satisfied with services provided than were those parents who had children in elementary (K-6) schools. For example, as highlighted in Chart 8-1B, parental satisfaction with student outcomes is lower for those parents with a child with special health needs in either a junior or senior high school as compared to parents who had a child in an elementary school.

[5] It should be noted that as some parents noted that their child's attendance was satisfactory prior to and after the implementation of the SHI, student attendance was not an issue among all parents surveyed.

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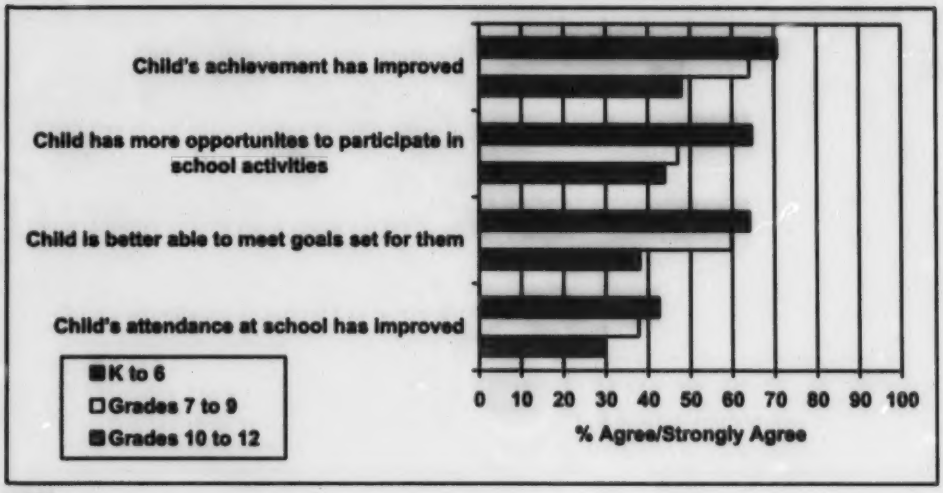
Chart 8-1B
Parental Opinion About Changes in Services
by Student Grade Level


Child's achievement has improved
Child has more opportunites to participate in school activities
Child is better able to meet goals set for them
Child's attendance at school has improved
K to 6
Grades 7 to 9
Grades 10 to 12
0 10 20 30 40 50 60 70 80 90 100
% Agree/Strongly Agree

n=270

Review of Partnership Annual Reports suggest most partners have observed positive outcomes.

Although the level of analysis varies by Partnership, it appears that most Partnerships are confident that the SHI has resulted in positive outcomes. Typical positive outcomes cited include:

- increases in the number of students served above 1998/99 levels and, in most cases, above targeted service levels planned for 1999/00;
- positive reaction to programs and services as collected through surveys of parents, service providers and school-based staff;
- reductions in wait lists and faster response to service needs;
- other positive outcomes (i.e., increase in the proportion of students who have multiple needs being met, increased coordination of services, etc.).

8.2 Identification of Unmet Needs

A secondary objective of the outcomes assessment was to identify any unmet needs that might exist with respect to the Student Health Initiative. Information regarding unmet needs is based on interviews with regional partners, service providers and upon review of submitted Annual Reports.

Although most Partnerships stated that they were now providing more/enhanced services, several Partnerships noted areas that still required services.

It should be noted that while most Partnerships were satisfied with their provision of more/improved services, several Partnerships noted that they had experienced difficulty in recruiting and providing services in the following areas:

- speech language; and
- behavioural specialists.

Some consideration should be given to expanding the scope to include additional populations.

Although most evaluation participants expressed that the Student Health Initiative should not be viewed as a panacea for all student health issues, there were several areas in which respondents acknowledged that there were service delivery gaps. Among these gaps included services to on-reserve Aboriginal students, pre-school aged children and "at risk" students.

On-reserve Aboriginal Students

Several partners expressed concerns about the inability to provide services to Aboriginal students who attended on-reserve schools. Several individuals stated that health needs of on-reserve Aboriginal students attending band schools were as great or greater than those of other Aboriginal and non-Aboriginal student groups.

Pre-school Aged Children

Several service providers felt that it would be important to provide services to younger children prior to enrolment in an ECS/school program. It should be noted that children with mild/moderate disabilities can be accepted into ECS as early as age three years six months and a child with a severe disability can be accepted at age two years six months. Some service providers, noted, however, that they would like to be able to provide services to children as young as two years of age.

Provision of Services to "At Risk" Students

It was noted that the Student Health Initiative targets children with special health needs. However, some service providers noted that the Initiative should also be able to provide support services (such as counselling or therapy) to "at risk" student populations including victims of abuse and school bullying. In addition, selected services should also be available to dropouts or recent graduates. Some Partnerships noted that the SHI should be extended to include violence prevention programs as well as parenting courses.

Some need to examine the provision of "culturally sensitive" programs and services.

In addition to general problems associated with staffing newly created positions, partnerships had problems in recruiting staff in the following areas:

- French language staff (few Partnerships indicated that they had French-speaking service providers)

- staff who could provide service in a second language. Partnerships noted that while this was not a major issue, the provision of services could benefit from having a workforce that was more culturally diverse.

8.3 Overall Assessment of the Student Health Initiative

In addition to commenting on individual elements of the Student Health Initiative, evaluation participants were asked to provide an overall assessment of the value and importance of the Initiative.

Stakeholders, regional partners, service providers and parents were very positive in their overall assessment of the Student Health Initiative.

Notwithstanding issues or concerns identified with implementation and funding, almost all evaluation participants indicated that the Student Health Initiative was a positive development enhancing both the quality and quantity of health services provided to students with special health needs, for example:

- 84.0% of Partnerships agreed or strongly agreed that the time and effort spent in forming the partnership was worthwhile given the additional resources provided;
- 84.0% of Partnerships indicated that participation in the SHI was a positive experience for their partnering organizations;
- almost all (92.0%) Partnerships agreed or strongly agreed that the Partnership has or will improve outcomes for students with special health needs with only two of the 24 Partnerships surveyed indicating that they were unsure as to whether the SHI would result in an improvement in such outcomes.

Implementation of the Student Health Initiative has resulted in several unanticipated positive outcomes.

In addition to the direct, positive benefits associated with improved health services to special needs students, evaluation participants noted several other unanticipated positive outcomes, including:

- Partnerships have been used as a model to help define/deliver other services. Several Partnerships reported that their Partnership has facilitated the introduction/planning of other joint initiatives such as the FAS Initiative, Family Violence Prevention and other health or social programs.
- Partnerships have significantly enhanced Partner knowledge of the service provider community. Many educational organizations noted that their participation in the Partnership had provided them with a better appreciation of the range of services provided by health and mental health service agencies. This knowledge has resulted in faster and more appropriate referrals to other health services that may be required by students and/or their families.
- Partnerships have made members more receptive to cross-department Initiatives. Several regional partners indicated that due to the success of the Student Health Initiative, their organization would be more receptive to cross-department initiatives. However, the experiences learned from the SHI would result in the Partnerships

having a better understanding of time/resource commitments associated with use of a "Partner Model" for service delivery.

Numerous positive comments were provided about the Student Health Initiative. A sample of such comments has been provided to illustrate the range of experiences of SHI participants.

"This was a home-run for the government. For a relatively small amount of funding, the Initiative sparked a tremendous amount of regional planning and collaboration."
-Regional Partner

"It was a worse-best experience…. but, in the end, things worked out well and enhanced services were provided to children."
-Former PWG Member

"This is the best example of what they were trying to do with the Alberta Children's Initiative."
-PWG Member

"We are still working out teething problems. Communication, reporting and accountability are all issues that we still need to address, but at least we now have resources that we did not have before."
-Regional Partner

PART C: SUMMARY AND CONCLUSIONS

Highlighted below are the Consultant's observations and conclusions associated with the formative evaluation of the Student Health Initiative.

SECTION 9: SUMMARY OF OVERALL EVALUATION CONCLUSIONS

Overall, the results of the *Student Health Initiative Evaluation Project* suggest that the Initiative is meeting an important need in the provision of health services to students with special health requirements. Information collected during the evaluation confirms that the Student Health Initiative has substantially increased the collaboration, coordination and overall delivery of services to special needs students.

Results further suggest that the SHI is realizing many positive successes regarding student outcomes. For example, Partnerships reported that the Initiative has resulted in more students receiving services, the delivery of more specialized services, reduced waiting times and extension of services to student populations that were traditionally under-served or not served at all. As well, information obtained from parents suggests that the Initiative has resulted in their child(ren) being better able to meet learning goals, has contributed to greater participation in school activities and has led to overall improvement in their child's achievements at school.

Notwithstanding the considerable time and resources required to establish the Partnerships and develop Joint Service Plans, these Partnerships are viewed as a key success factor for the Initiative. The inclusion of all partners was seen as a building block in the development of an integrated and coordinated service delivery plan that met the needs of all children, irrespective of the school district or authority to which the child was affiliated. Almost all Partnerships noted that, despite the time and resources involved, participation in the Student Health Initiative was a worthwhile endeavor.

While the Student Health Initiative can be characterized as a "positive" initiative, evaluation participants noted that there were a number of challenges associated with implementation. Lack of time, insufficient financial resources and only limited provincial support were identified as challenges or barriers to effective implementation. Similarly, almost all Partnerships noted that they have been unable to fill many staffing positions and, as a result, have recorded a significant surplus in the first year of operation. Staffing concerns were identified as a key issue in terms of implementation, and many Partnerships continue to report that they have been unable to fill some positions.

Looking forward, it is clear that the Student Health Initiative will remain an important component in the delivery of health services to students with special needs. However, there are several areas that have been identified for review, including: funding, reporting requirements and addressing perceived service delivery gaps.

In summary, based on the review and synthesis of the extensive information collected as part of this evaluation, it appears that to the Partners involved in the Student Health Initiative, that the concept of the Initiative represents an effective model for coordinating the planning and delivery of health services to students with special health needs. It should be noted, however, that it was not within the scope of this evaluation to identify the extent to which the SHI has influenced long-term outcomes with respect to student health and learning outcomes. Such analysis would need to be part of a more comprehensive summative evaluation.

Malatest & Associates Ltd.

RECOMMENDATIONS
THE STUDENT HEALTH INITIATIVE
EVALUATION PROJECT

Prepared for
THE STUDENT HEALTH INITIATIVE
EVALUATION COMMITTEE

Prepared by:
R.A. Malatest & Associates Ltd.
206 – 10050 112TH Street
Edmonton, AB T5K 2J1

Phone: (780) 448-9042
Fax: (780) 448-9047

Date: January 2001

CONSULTANT'S RECOMMENDATIONS

Detailed in this report are the Consultant's recommendations with respect to program design, implementation, funding and monitoring and evaluation.

Overall, the results of the evaluation suggest that the Student Health Initiative (SHI) has had a positive impact in terms of enhancing the coordination and delivery of student health services to students with special health needs. Notwithstanding the high levels of satisfaction among Partnerships, stakeholders and parents, there are several areas that have been identified which could further enhance the overall effectiveness of the Student Health Initiative.

The recommendations provided below have been based on a synthesis of considerable qualitative and quantitative information gathered during the course of the evaluation as well as a review of administrative information (i.e., Planning Guide, Partnership Annual Reports, etc.). As some recommendations reflect "lessons learned", they are intended to serve as a guide in the development of similar programs or initiatives in the future. Other recommendations address identified shortcomings in the Initiative, as well as area/activities that could be undertaken to enhance the overall effectiveness of the Student Health Initiative. Although recommendations will undoubtedly overlap in several areas, recommendations have been grouped under the following main headings to facilitate the review of the Student Health Initiative. These areas include:

1. *Recommendations in the Area of Program Design and Implementation*
2. *Funding Related Recommendations*
3. *Recommendations in the Area of Communications*
4. *Recommendations in the Area of Parent Involvement*
4. *Monitoring and Evaluation Recommendations*

1. Recommendations in the Area of Program Design and Implementation

A key objective of the process evaluation was to identify lessons learned so that future similar initiatives could benefit from these key observations. Detailed below are the key lessons learned and/or associated recommendations in the area of program design and implementation.

1-1 The SHI represents an excellent model to promote inter-agency collaboration and service delivery coordination and should be adopted for similar inter-ministry initiatives.

The results of the evaluation suggest that use of a "Partner" model, with funding allocated on a pooled basis, contributed to significant collaboration and coordination of service delivery. Although Partner agencies noted that such collaboration required considerable time and resources, it did result in a more coordinated approach in the delivery of student health services. In this context, it would be appropriate to utilize the Student Health model for similar inter-ministry initiatives.

1-2 *Provide Partnerships sufficient time to form Partnerships and develop Joint Service Plans*

Almost all Partnerships noted that they did not have sufficient time to form the partnership and develop a Joint Service Plan. Evaluation participants noted that six months would have been a more appropriate time period.

1-3 *Need to provide necessary support during implementation and on-going administration*

Although the Student Health Initiative provided several useful support and implementation tools such as the Planning Guide and regional information sessions, many Partnerships indicated that additional supports would have facilitated the launch of the Initiative. These supports include:

- creation of SHI facilitation teams in the regions to support implementation; and,
- provision of additional funding to allow all Partnerships to hire a coordinator on a .5 FTE basis or greater.

1-4 *Anticipate demand for specialized resources or services*

The introduction of the Student Health Initiative resulted in a province-wide demand for health professionals. In the future, government departments should anticipate what impacts such initiatives will have and try to ensure that appropriate human resource strategies are in place to meet such demand(s).

1-5 *Consider expansion of eligible service/children served under the Student Health Initiative*

Some consideration should be given to expand the Student Health Initiative to facilitate the provision of the following services:

- services to Aboriginal students attending Band schools on-reserve;
- more services to pre-school aged children with mild/moderate disabilities; and,
- inclusion of other programs such as bullying, parenting and programs targeting "at risk" students.

2. Funding Related Recommendations

2-1 *Recognize and fund the considerable administrative activities associated with participation in the Student Health Initiative.*

Almost all Partnerships noted that they incurred administrative costs that were well in excess of the 4.5% allocation. Partnerships noted that in addition to direct staff costs, there were other costs such as overhead (e.g., telephone, computer) and accommodation costs that

were not funded under the Student Health Initiative. Administrative requirements associated with participation in the Initiative (i.e., evaluation, Annual Reports, etc.) also represent significant costs to the Partnerships. In this context, it is recommended that government review current administrative funding allowances and adjust as appropriate.

2-2 Irrespective of size, most Partnerships require a coordinator position

Due to the complexity of the Initiative, and the need to form partnerships and generate consensus with respect to service priorities, almost all Partnerships felt that there was a need to establish a coordinator position. While such position could be funded out of the administrative allocations in the larger partnerships, many of the smaller partnerships (i.e., those whose total SHI funding was less than $750,000) noted that there was insufficient funds to hire a coordinator on even a part-time (.4 to .5) basis. The Consultant recommends that base funding be provided to allow each Partnership to hire, at the minimum, a coordinator that could be funded at a .4 FTE basis.

2-3 Recognize service delivery costs for rural/remote regions

During site visits, it was emphasized that service delivery costs for rural or remote regions was considerably higher due to travel arrangements and the geographic dispersion of students. Stakeholders noted that the current SHI funding model did not account for the "cost of delivery" but, rather, was funded on a per-student basis. The Consultant recommends that the government review the equity of the current funding formula and adjust funding to reflect regional differentials in the cost of service delivery.

2-4 Clarify future/long-term funding of the Initiative

Many Partnerships noted that it would be important to have a long-term commitment to funding associated with the Student Health Initiative to clarify staffing and accommodation requirements. In this context, it is recommended that the government adopt a three year rolling model whereby future funding for a three year period is specified.

2-5 Provide additional funding to cover cost of living/wage settlements

The current funding formula does not explicitly include any adjustments for inflation and/or wage settlements. Notwithstanding the large surplus position recorded in many Partnerships in Year 1, many Partnerships noted that they will either have to reduce services and/or incur a deficit in Year 3 if no additional funding is provided. It should be noted that wage settlements for many of the health staff are beyond the control of the individual Partnership(s) and reflect province-wide settlements.

3. Recommendations in the Area of Communications

3-1 Provide a mechanism to support Partnership communications and information sharing

Almost all Partnerships expressed that it would be beneficial to share experiences as well as gain insight as to "best practices" in other regions. In this context, the Consultant recommends that the Provincial Working Group (PWG) and/or Partnerships continue to produce and distribute regular newsletters and/or information updates. In addition, the PWG should review the feasibility of establishing an internet website with a "bulletin board" function to facilitate further information sharing between Partnerships.

4. Recommendations in the Area of Parental Involvement

4-1 Enhance information available to parents and communities

The results of the evaluation suggest that even as late as fall 2000, parent knowledge of the Student Health Initiative is limited. The PWG and Partnerships may wish to examine the feasibility of developing communication materials that better explain the concept of the Student Health Initiative. Provincial development of such materials should incorporate feedback/requirements of the Partnerships.

4-2 Strengthen the input of parents and the community in SHI Partnerships

Many Partnerships have yet to incorporate parents and the general community formally in governance and/or advisory capacities. To ensure parents have a role in the design and delivery of programs at the regional level, the PWG should consider modifying the governance structure as detailed in the Planning Guide so that the Partnerships must include minimum parent representation (i.e., 1 or 2 parent representatives). Alternatively, Partnerships should actively pursue mechanisms (both formal and informal) to ensure parental input into the Partnership.

5. Monitoring and Future Evaluation Recommendations

5-1 Specify data collection and reporting requirements

Currently, there is a considerable range in data collection and reporting activities being completed by the individual Partnerships. For example, whereas some Partnerships have established formalized data collection activities to provide for the comparability of formalized data collection activities, other Partnerships have yet to specify common data elements to be captured and reported by each service provider.

To provide clarification as to data collection activities, the PWG should identify minimum provincial data requirements. Again, the PWG should clearly specify the reasons for such data collection requirements in terms of additional administrative activities that will be borne by the Partnerships.

5-2 Consider the development of standardized data collection/evaluation tools

Several Partnerships indicated that they were in the process of designing and implementing their own surveys of parents, school officials and/or service providers. While the Consultant recognizes that each Partnership will have unique issues/service delivery structures, it would be beneficial for the PWG in consultation with the Partnerships, to develop some standard questions/scales that should be utilized in the surveys. This would allow the PWG to have Key Performance Indicator (KPI) data for every Partnership. Standardized instruments should be developed for use in parents, school and service provider surveys.

Consistent with development of a format structure for the Annual Report, the PWG may also wish to develop a similar template for internal evaluation(s)/self assessment(s) that can guide the Partnerships in current and future program evaluations.

5-3 Standardize Annual Report requirements

Currently, the SHI specifies minimum requirements for Partnership Annual Reports. However, in review of the 13 Annual Reports provided to date, there were considerable discrepancies in the format and content of each report. To facilitate production of such reports in the future, the PWG should clearly specify the information that is required and provide a format for such information (similar to the Form 3 currently provided). Ideally, the PWG would develop a report template that could be distributed to all Partnerships to facilitate the production of future Annual Reports.